



# Leading The Way:

**USAID  
Responds  
to HIV/AIDS**  
1997-2000



U.S. Agency for  
International  
Development

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Photo: Rich Marchewka

## *USAID: Leading the Way*

### **Every Six Seconds**

Every six seconds, someone around the world is infected with the virus that causes AIDS. Like the plague that swept Europe in the Middle Ages, AIDS is devastating entire continents while undermining progress: life expectancies are falling, child mortality is rising, and standard indicators, such as economic growth, literacy rates, and food production, are slowly sinking.

AIDS has killed more than 22 million people around the world. Today, more than 36 million people live either with HIV or AIDS, and the pandemic shows no signs of slowing. Last year, more people contracted HIV and more died of AIDS than in any other year. The vast majority of these people—95 percent—live in the developing

world, and the vast majority suffer and die in the prime of their lives.

But children, too, are affected. Largely due to mother-to-child transmission, 500,000 children died of AIDS, and another 600,000 were infected in 2000 alone. Again, more than 95 percent of these children live in the developing world. The AIDS pandemic has also orphaned more than 13 million children, most of them in sub-Saharan Africa. By 2010, this number is expected to mushroom to 36 million—more orphans than the entire population of California.

Densely populated regions such as South Asia and Eastern Europe, where HIV/AIDS has thus far been found among populations engaging in high-risk behaviors, stand on the brink of

becoming the next epicenters. Studies of injecting drug users in parts of India, for example, have shown infection rates as high as 70 percent.

The sense of urgency has never been greater.

### **Leading the Way**

Since 1986, the U.S. government, working primarily through the U.S. Agency for International Development (USAID), has dedicated more than \$1.6 billion to prevent and lessen the impact of HIV/AIDS in the developing world. Currently, the United States provides approximately half of the global resources to fight HIV/AIDS—four times the amount of the next largest donor.

USAID works in more than 50 of the hardest-hit countries,



with primarily community-based organizations, which have the best access to the most vulnerable and underserved populations. USAID's response employs a number of integrated tactics: prevention, treatment, care for vulnerable populations, including orphans and other children affected by AIDS, surveillance to track the pandemic, and collaboration with members of the global community who are also fighting the disease.

If it were not for the groundbreaking work to which USAID has been the major contributor over the past 15 years, the world would be much further behind today in fighting the pandemic now that global attention has been focused finally on HIV/AIDS and resources are beginning to increase.

USAID-funded research pioneered the development of many of the tools that are now the standard for AIDS prevention programs across the globe. In the late 1980s, USAID supported the development of simple HIV testing to ensure the safety of blood transfusions, along with one of the first condom social marketing programs, which later served as a global model.

In the early 1990s, USAID was one of the first organizations to recognize that managing sexually transmitted diseases also reduced HIV infection. In 1995, USAID supported studies that proved that increasing access to voluntary, confidential HIV counseling and testing can lead to a reduction in risk behav-

iors. Today, we have voluntary counseling and testing programs in close to a dozen countries.

In 1996, USAID played a key role in the creation of the Joint United Nations Programme on HIV/AIDS (UNAIDS), which has become the major multilateral leader in prevention of HIV/AIDS. In 1997, USAID was instrumental in recognizing the essential roles that care, treatment, and support play in enhancing prevention efforts, and we now have care and support projects in 14 countries. Also in 1997, USAID called the world's attention to the tragedy of AIDS orphans, and caring for orphans and other children affected by AIDS is now integral to many countries' AIDS strategies. In 2000, USAID-sponsored U.S. Bureau of the Census research on the demographic impact of AIDS, which served to alert the public of the disease's devastating reach.

While USAID supports the concept of a prevention-to-care continuum, the cornerstone of USAID's fight against HIV/AIDS is prevention. USAID understands that lasting prevention requires individual as well as societal behavioral change.

Over the past decade, USAID has supported public education and awareness campaigns that reached millions of people. Through both traditional and more unconventional means, such as rock concerts, TV programs, and ad campaigns, prevention messages have saved



Photo: Rich Marchewka

countless lives. On a local level, USAID has provided assistance so that communities can provide intensive, interpersonal HIV education and counseling to more than 30 million individuals—greatly reducing their risk of contracting HIV. On an annual basis, USAID's condom distribution efforts avert more than half a million infections globally.

USAID is helping people living with AIDS by focusing on the prevention and treatment of AIDS-related illnesses such as tuberculosis, the leading cause of death in patients with AIDS: in sub-Saharan Africa, for example, more than half the people with active tuberculosis are also HIV-

positive. USAID's programs for children affected by AIDS are designed to help not only the children, but also the communities in which they live. And USAID's efforts to increase surveillance capacity have helped countries better target AIDS education and prevention efforts.

## Working Together

As strong as USAID's commitment to fighting the AIDS pandemic is, the agency realizes that the U.S. government cannot do it alone—the challenges are too broad, the need too great, and the devastation too widespread. That is why collaboration with a wide range of partners—including national governments, the World Bank, the United Nations, and U.S. and local organizations—is a hallmark of USAID's HIV/AIDS program. In the past two years, new partners within the U.S. government—the Centers for Disease Control and Prevention, the Peace Corps, and the Departments of Defense, Labor, State, and Health and Human Services—have all joined

USAID in the fight against HIV/AIDS.

The private sector can and does contribute to the fight against HIV/AIDS in the developing world, and USAID continues to look for ways to increase opportunities to collaborate with private industry. One exciting development is the Global AIDS and Health Fund, which will generate additional resources from both the public and private sectors. As with every other development milestone, USAID believes that meeting the challenge of AIDS can be accomplished only with the full participation of all sectors of society.

The need for this kind of participation is immense. We are only now beginning to comprehend the long-term devastation this disease has wrought. In sub-Saharan Africa, the labor force is expected to be reduced by 10 to 30 percent due to HIV/AIDS. By 2025, the economy in Botswana is expected to be nearly one-third smaller than it would have been were it not for HIV/AIDS. The Government of Swaziland estimates that by 2016 it will

need \$200 million—the size of the entire Swazi budget in 1998–1999—just to replace teachers lost to AIDS.

## Rays of Hope

Among the foreboding statistics there are rays of hope: USAID's work in India, in Uganda, and in Cambodia, among other places, has shown that prevention messages work. The imperative now is to “scale up” these efforts while addressing the needs of the millions living with and affected by HIV/AIDS.

As overwhelming as the challenge may seem, the international community has come together in the past to defeat other diseases, with impressive results. Smallpox was defeated. Polio is on track for eradication in the next five years. This is the promise that comes with worldwide cooperation and dedication to one goal—that of protecting the health and well being of all the world's people.

As the world enters the 21st century and the third decade of AIDS, that promise has never been greater or more important.







Photo: USAID

## *AIDS and Its Impact: The Global Crisis*

Twenty years after it was first identified, acquired immune deficiency syndrome (AIDS) has become far more widespread and devastating than initially predicted, affecting men, women, and children in all parts of the world. Approximately 22 million people have already died from the disease, and today 36 million people live with either AIDS or human immunodeficiency virus (HIV), the virus that causes AIDS. In the year 2000 alone, 3 million people, including 500,000 children, died of AIDS; and 5.3 million people, including 600,000 children, were newly infected with HIV.

Understanding of the causes and consequences of HIV/AIDS has grown enormously. HIV/AIDS is now the focus of extensive international attention, and much has been learned about

what is needed to prevent and respond to HIV infection. But the response has not kept up with the pace of new infections. As the pandemic spreads, it becomes more complex, and today HIV/AIDS is not just a health crisis, but a social and development crisis of major proportions. The vast majority of all people infected—95 percent—live in the developing world. Development progress achieved over four decades is being undermined, and economic growth and political stability are threatened.

### **The Face of the Pandemic: Complex and Changing**

In the early 1990s, health experts warned that by the beginning of the 21st century, approximately 15 to 20 million people would be living with

HIV. Now, 10 years later, the actual number is twice the experts' worst predictions. Improved surveillance and accumulating evidence clearly show that the AIDS pandemic is more powerful and more complex than initially realized; it can show rapidly changing patterns as it spreads through communities and cultures. Among the major trends:

***The pandemic shows no signs of slowing.*** Every month, 440,000 people become newly infected. And while transmission has slowed in enough places to show that prevention can work, more people acquired HIV and more people died of AIDS in 2000 than in any previous year. Even if no new infections occurred, the number of AIDS deaths would continue as those already infected get sick and die.

***Africa remains the epicenter of the pandemic.*** The world's poorest and most vulnerable region, sub-Saharan Africa, has borne the brunt of the pandemic, accounting for more than two-thirds of people now living with HIV/AIDS (25.3 million out of 36.1 million people). Although HIV/AIDS is the fourth leading cause of death in the world, it is the leading cause of death in Africa. Women and children in Africa are particularly vulnerable to HIV/AIDS and its consequences. Africa is the only region in which more women than men are infected with HIV (55 percent of HIV-infected adults are women). It is not only home to three-quarters of the world's children infected with HIV, it is also home to 90 percent of the children who have been orphaned as a result of AIDS, and to millions more whose daily lives and well-being are affected by their parents' illness.

***Asia could eclipse the African epidemic.*** The second largest regional epidemic is in the Asia Pacific region, where nearly 60 percent of the world's population lives. With its dense populations, this part of the world could eclipse the African epidemics. The epidemic has exploded in Cambodia, Burma, Thailand, and some states of India. Other countries in the region, most notably the Philippines, have maintained low prevalence levels over the last decade, giving rise to hope that with successful behavioral interventions, this region's epidemics can be contained.

***Even small increases in prevalence in countries with large populations could rapidly increase the number of cases worldwide.*** China and India together account for more than one-third of the world's population. Although the overall prevalence is low in both these countries, they contain pockets with higher levels of infection. At least two states in India, for example—Tamil Nadu, with a population of 62.1 million, and Maharashtra, with a population of 96.8 million—have HIV/AIDS prevalences of greater than 2 percent. Studies of injecting drug users in some parts of India have shown a prevalence of as high as 70 percent. Unless prevention measures succeed in reaching high-risk individuals, they will eventually spread the infection to their sexual partners, which will bring the disease into the general population. In countries with such large populations, even a relatively lower prevalence than those existing in Africa would substantially increase the number of HIV/AIDS cases.

***In some countries, HIV infection is increasing rapidly.*** While the absolute numbers of HIV cases in Russia and Ukraine may be small, the Eurasia region as a whole is showing the world's sharpest increase in HIV infection, reaching 420,000 cases in 1999—a doubling in just two years. Although the epidemic is still limited to a small number of groups engaging in high-risk

behavior, a number of conditions and behaviors could precipitate a rapid increase in transmission: a dramatic surge in sexually transmitted infections, increased drug trafficking and use, widespread poverty and migration, declining health and education services, and a general climate of rapid social change.

***Heterosexual transmission is accelerating the spread of HIV.*** While HIV was initially believed to be limited to high-risk behaviors—such as injecting drug use, commercial sex, and sexual contact between men—it is now spread primarily through heterosexual contact. Worldwide, 70 percent of new HIV infections are acquired through unprotected heterosexual contact. In the regions hardest hit by the virus—sub-Saharan Africa and South and Southeast Asia—it is the primary mode of transmission.

***The rate at which women are becoming infected is increasing rapidly.*** Women—especially girls and young women—have special biological, behavioral, and social risk factors that put them at increased risk of contracting HIV/AIDS. In many countries, women face varying degrees of sexual, social, and economic subordination. Lacking power in their personal relationships and having few independent economic opportunities, women may be unable to insist on their partner's sexual fidelity or condom use. This puts them at serious risk for

contracting HIV/AIDS even when they themselves are monogamous.

In every region, the number of HIV-infected women is growing rapidly. Today, women represent 47 percent of adults infected with HIV/AIDS (up from 25 percent in 1992 and 41 percent in 1997). In Africa, the number of HIV-infected women now exceeds the number of men infected.

***Millions of children are made vulnerable by HIV/AIDS.***

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), AIDS has orphaned approximately 13.2 million children under age 15 since the pandemic began. In at least eight African countries, between 20 and 35 percent of children under age 15 have lost one or both parents. Millions of additional children are not yet orphaned but live with ill parents in households that are at increased economic risk. By 2010, 44 million children in 34 developing countries will have lost one or both parents, primarily from AIDS.

The effect of so many orphans and other vulnerable children is substantial—for the children themselves, the families that step in to care for them, and the communities in which they live.

Not only do children lose the security and safety of their immediate families, they frequently end up taking on adult responsibilities at very early ages. They provide care for ill or dying parents, take over farm

*In countries where 15 percent of adults already have HIV/AIDS, approximately one-third of today's 15-year-olds will die of AIDS.*

and household work, care for younger siblings, and earn money for basic necessities. They are forced to give up school, have less access to health care, and become vulnerable to mal-

nutrition as family resources dwindle. Particularly in sub-Saharan Africa, where most of the AIDS orphans and HIV-infected children reside, prior gains in improving child health are eroding. At this point, only a handful of countries in the region are expected to meet internationally agreed infant and child mortality targets by 2015. In some countries, infant mortality rates are now higher than in 1990.

Extended families and communities are providing the bulk of care to AIDS orphans, with little if any social infrastructure in place to provide assistance. Surviving spouses, who may themselves be ill, grandparents, aunts, uncles, and siblings are taking care of HIV-affected children. Many caregivers are too old, too young, or too impoverished to meet these unexpected responsibilities adequately; they

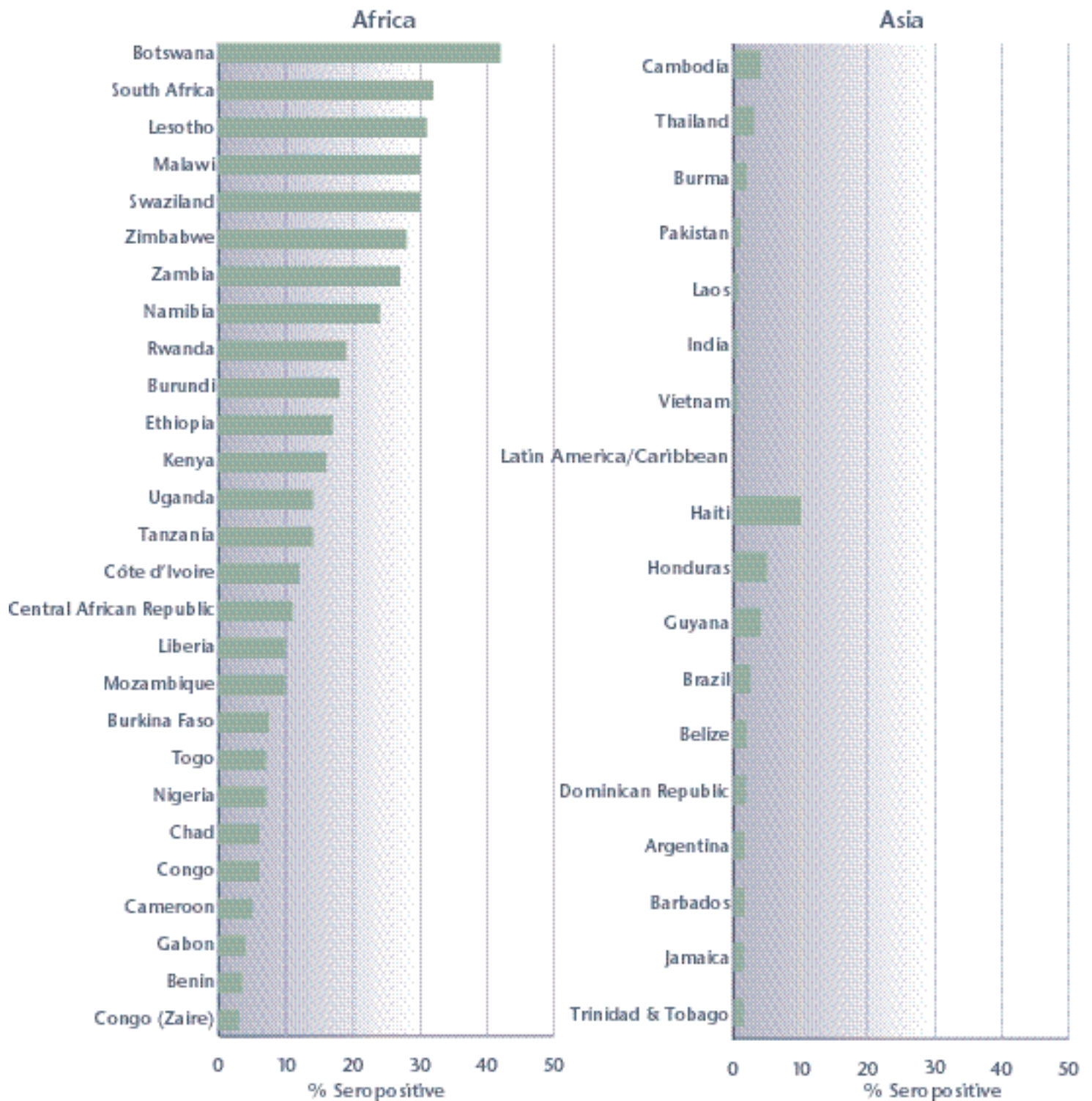
may be ill or grieving. The first “post-pandemic” censuses now being carried out will eventually provide data on the changing nature of families in the hardest hit countries. In the meantime, limited survey data and anecdotal evidence suggest that in some places, nearly three-quarters of families include at least one AIDS orphan.

***Young adults are at high risk of acquiring HIV.***

Young adults between the ages of 15 and 24 are at particularly high risk, especially in countries with high prevalence levels. In countries where HIV/AIDS is spread mainly through heterosexual transmission, most who get infected do so by the time they are in their 20s or 30s, and die within a decade. For teenagers in the most severely affected countries, the risk of acquiring HIV/AIDS is substantial. New studies show that, even under conservative assumptions, in countries where 15 percent of adults already have HIV/AIDS, approximately one-third of today's 15-year-olds will die of AIDS. In countries with even higher prevalence levels, half or more of current 15-year-olds will lose their lives to AIDS. More than 10 million people aged 15 to 24 are now living with HIV/AIDS, and half of all new infections occur among young people. Young women are particularly vulnerable. In some urban African settings, young women aged 15 to 19 have six times the rate of HIV infection of their male counterparts.



## HIV-Seroprevalence Among Pregnant Women from Capital or Major Urban Centers in Selected Countries



U.S. Census Bureau, Population Division International Programs Center, HIV/AIDS Surveillance Database, June 2000

Even though they are at greatest risk, young people also offer great hope because they appear to be leading the way in reducing risky behaviors. Studies show that where HIV prevalence is declining or leveling off, decreasing infection rates among young people are usually the first sign of an overall downturn.

***Stigma is a major obstacle to combating HIV/AIDS.***

Overcoming the stigma attached to HIV/AIDS and the resulting discrimination is essential to combating the pandemic. In too many places, those with HIV/AIDS are deprived of their property or rights: ostracized or forced to physically leave their homes or villages, disinherited (especially children and women), or made into outlaws (by making homosexuality a criminal offense, for example). Stigma is also attached to certain modes of HIV transmission, which may involve behaviors considered unacceptable in some cultures. Involving people living with HIV/AIDS in prevention and care programs helps to overcome stigma and discrimination and encourage greater participation in such programs. Their input identifies the most pressing needs of those infected and their families, and ensures that programs are truly providing the most critical services.

HIV/AIDS is feared because it is a fatal disease, and people cope with that fear by stigmatizing those who have it. By using discrimination to separate themselves from people with

HIV/AIDS, they feel safer and more powerful. Yet stigma and discrimination have the opposite effect, making everyone more vulnerable. Stigma and discrimination push people in high-risk groups (e.g., sex workers, injecting drug users) underground, making them difficult to reach through prevention programs and thus creating more opportunities for HIV/AIDS to spread to the general population. Moreover, when HIV/AIDS is stigmatized, all people become more reluctant to get tested and learn about the specific steps they can take to avoid infection.

## **The Effect of HIV/AIDS on Development**

By any measure, HIV/AIDS is a health crisis of unprecedented proportions—a health crisis with no “magic bullet” to either prevent or cure it. But with 95 percent of infections occurring in the developing world, particularly the poorest parts of the developing world, it is also a development crisis threatening to stop—and even reverse—the health advances and other gains that have been made in many countries over the last several decades. Particularly in Africa, HIV/AIDS is already resulting in severe economic and social damage.

In some parts of the world, the pandemic has already crossed into the general adult population; in others, it appears still to be concentrated within the highest risk groups (see Stages

of the Epidemic box p. 13). But everywhere, the fight against HIV/AIDS is a fight against time. The damage done by this disease is already so great that it is hard to imagine it getting worse. But it will get worse if preventive measures are not rapidly scaled up. The millions already infected, and those still getting infected, are largely young adults. Within a decade, without access to new antiretroviral treatments, they will almost certainly be dead.

HIV/AIDS differs from most other diseases in that it strikes men and women in their most productive years, is inevitably fatal, and leaves in its wake dependent children and parents who then struggle to care for themselves and each other with even fewer resources than they may have had. The effects are felt first at the household and community levels, and eventually in the larger society and national economy.

### **Effect on Families**

From the time the affected family member first becomes ill, through the progression of the disease, death, and beyond, households in which one or more members has HIV/AIDS are affected in multiple ways. The most immediate effect may be the loss of the affected person's income. If the main breadwinner is ill, the loss could be significant at the very time that household medical expenditures may be increasing. In addition, other members of the household, especially daughters and



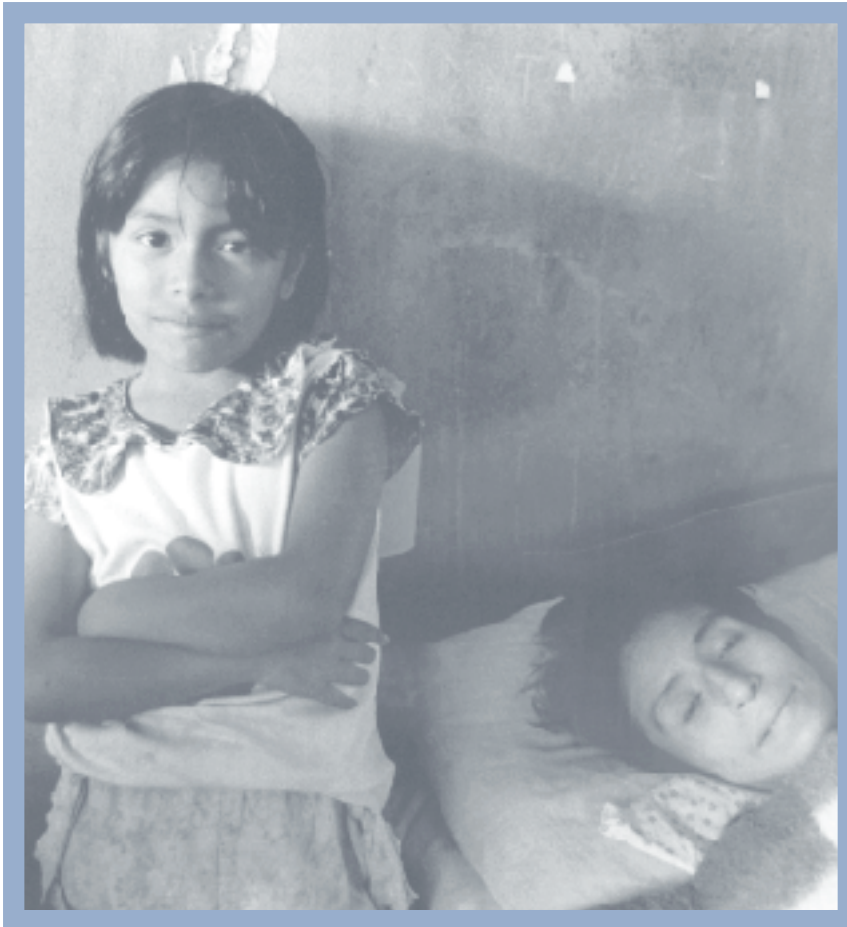


Photo: Panos Pictures © Annie Bungeiroth

wives, may need to leave school or work to provide care for the ill family member, further decreasing the household's resources and longer-term prospects. When the family member dies, children may need to be permanently removed from school to save tuition and uniform fees, and they may have to work to make up for the lost income. In addition, the household may have spent any savings it had accumulated to provide care and an appropriate funeral, or it may have depleted its grain stock or sold livestock to feed mourners.

The loss of savings and productive assets affects the family's ability to survive. Studies in a number of countries have

quantified these effects. In Ethiopia, for example, a study of 25 AIDS-afflicted rural families found that the average cost of treatment, funerals, and mourning expenses was several times the average household income. In Côte d'Ivoire, households with a member living with HIV/AIDS spent twice as much on medical expenses as other households, with 80 percent of expenditures devoted to the person with HIV/AIDS rather than other family members.

But the effect on the household is not just economic. When adults in the family die, the very structure of the family changes. Grandparents, aunts, uncles, and even children take on new responsibilities at the same time

that they are coping with their own feelings of loss and mourning. With fewer household resources and less available time, children receive less access to health care and are more vulnerable to malnutrition. In some places, children are at risk of having their property or inheritance taken from them and of suffering stigma and discrimination.

### Effect on the Community

HIV/AIDS is creating enormous challenges for communities throughout the developing world. In addition to the large numbers of orphans, communities are losing significant numbers of their most productive adults. Yet, throughout the developing world, where there may be few if any formal social service agencies or government services, communities are managing to provide support to children and families affected by HIV/AIDS. They are taking the responsibility because there is no one else to do it.

In many places, community members are creating volunteer organizations that serve as safety nets for children and families. These community groups identify vulnerable children, mobilize local resources, and establish day care centers. Increasingly, such groups are becoming effective and influential advocates by promoting other needed changes, such as increasing acceptance of women and young people in the power structure and the labor market, encouraging local leaders to protect property and inheritance rights of

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## States of the HIV/AIDS Epidemic

In partnership with USAID, UNAIDS and WHO in 2000 released a report that defined the three epidemiological states of the HIV/AIDS epidemic as low-level, concentrated, and generalized. Each state of the epidemic has important implications for public and private sector priorities in preventing the spread of HIV. Within a generalized epidemic, USAID terms epidemics with a prevalence of greater than 5 percent as high prevalence, and those with less than 5 percent as low prevalence.

### *Low-Level Epidemics*

This stage of the HIV/AIDS epidemic occurs in areas where HIV has not yet spread widely even among groups whose behavior puts them at risk. In these high-risk groups, HIV prevalence has not consistently exceeded 5 percent. Developing areas with low-level epidemics are estimated to include more than 40 percent of the world's population, half of the population of developing countries, and more than half of the population of low-income countries.

### *Concentrated Epidemics*

This stage of the epidemic occurs when HIV prevalence consistently exceeds 5 percent in one or more groups with high-risk behavior, but is still less than 1 percent in pregnant women in urban areas. Once HIV has reached high levels among those who are most likely to contract and spread the virus, containing the epidemic becomes increasingly difficult and requires additional proactive measures.

### *Generalized Epidemics*

In generalized epidemics, HIV is firmly established in the general population, and HIV prevalence is consistently more than 1 percent in pregnant women. Although high-risk groups may continue to contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain an epidemic, independent of high-risk groups.

Countries with a generalized epidemic will face two related sets of challenges. The first is establishing or maintaining prevention programs focused on those most likely to contract and spread HIV, while expanding prevention efforts to those with a somewhat lower risk of transmitting the virus. The second is mitigating the impact of AIDS sickness and death, especially among the poor.

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widows and orphans, and organizing cooperative child care and orphan visitation programs.

### **Effects on Society**

In developing countries with high rates of infection, almost every aspect of society is affected.

#### *Declines in Life Expectancy and Population Growth*

More than four decades of progress in improving health and life expectancy are now threatened in severely affected

countries. In southern Africa, in particular, where life expectancy at birth increased from 44 years in the 1950s to 59 years in the 1990s, and could have reached 70 years by 2010, life expectancy is falling dramatically. Within 10 years, many countries may have average life expectancies of only 30 years — a level not seen since the beginning of the 20th century.

In some countries, population growth will soon begin to decline as a result of high

HIV/AIDS mortality rates. U.S. Bureau of the Census research, commissioned by USAID and released in mid-2000, shows that by 2003, at least three African countries—Botswana, South Africa, and Zimbabwe—will have negative population growth because of HIV/AIDS, and five additional countries will have virtually zero growth. Other countries—the Bahamas, Burma, Cambodia, Guyana, and Thailand—will also experience declines in population growth. While slower population

growth is generally a development goal, it should be achieved by slowing the birth rates, not through an increasing death rate of society's young adults.

In many sub-Saharan countries, up to one-third of people in their prime will die of HIV/AIDS; in some countries, up to two-thirds will die. This change in the distribution of the population will affect almost every sector of society.

### *Increased Demand for Health Services*

HIV/AIDS affects the health sector in several ways. First, it dramatically increases the number of people seeking health care, overwhelming health care systems in the hardest hit countries. In many hospitals in Africa, for example, patients with AIDS occupy more than half of available beds. Second, health care for AIDS is expensive. In Zimbabwe, AIDS is projected to take up more than 60 percent of the Health Ministry's budget by 2005; in Kenya, more than 50 percent.

In settings with very limited resources, treating patients with AIDS requires important trade-offs: between treating AIDS and preventing HIV, between treating AIDS and treating other diseases, and between spending for health and spending for other

objectives. Determining what resources should be spent for what kind of AIDS efforts and mobilizing the resources needed

are important challenges facing countries already confronting very difficult circumstances. Finally, health workers are one of several professions on which HIV/AIDS is taking a particularly high toll.

Thus the number of health personnel may be declining at the same time that need is rising.

### *Declines in Agricultural Production and Food Security*

In most African countries, agriculture is the largest sector, contributing to both food security and income. The loss of even a few workers can make a signifi-

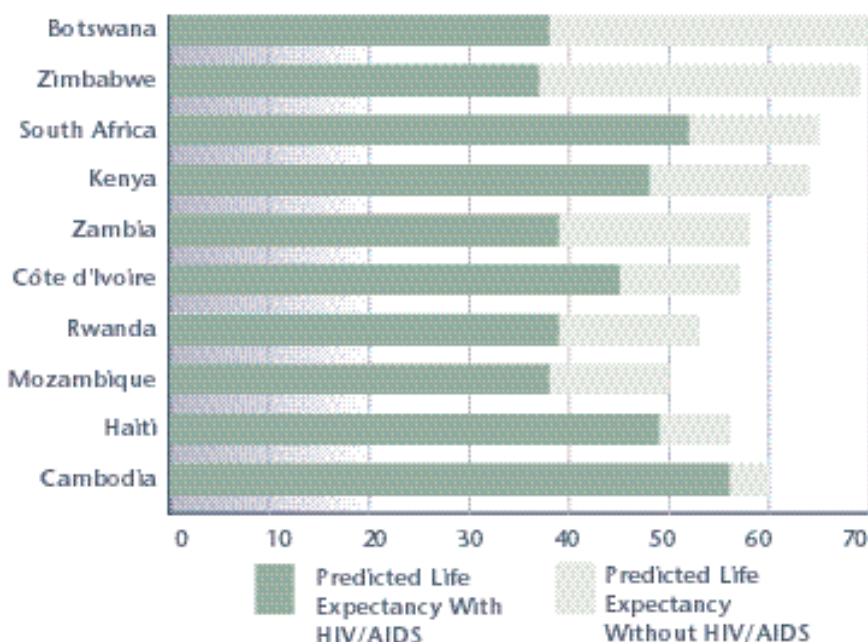
cant difference in the size of the harvest. In families that are dependent on subsistence-level farming, surviving children and family members sometimes go hungry after the farm worker in the family dies. As the number of people available to plant and harvest food declines, the production of both food crops and cash crops also declines. In Zimbabwe, for example, the death of a breadwinner from AIDS was found to reduce the marketed output of various crops anywhere from 29 to 61 percent.

### *Increased Expenditures and Decreased Revenues for Businesses*

In the hardest hit areas, AIDS-related illness and death can have a significant effect on the manufacturing sector both by increasing expenditures and by reducing revenues. Companies incur increased expenditures not

*In Zimbabwe, the death of a breadwinner from AIDS was found to reduce the marketed output of crops anywhere from 29 to 61 percent.*

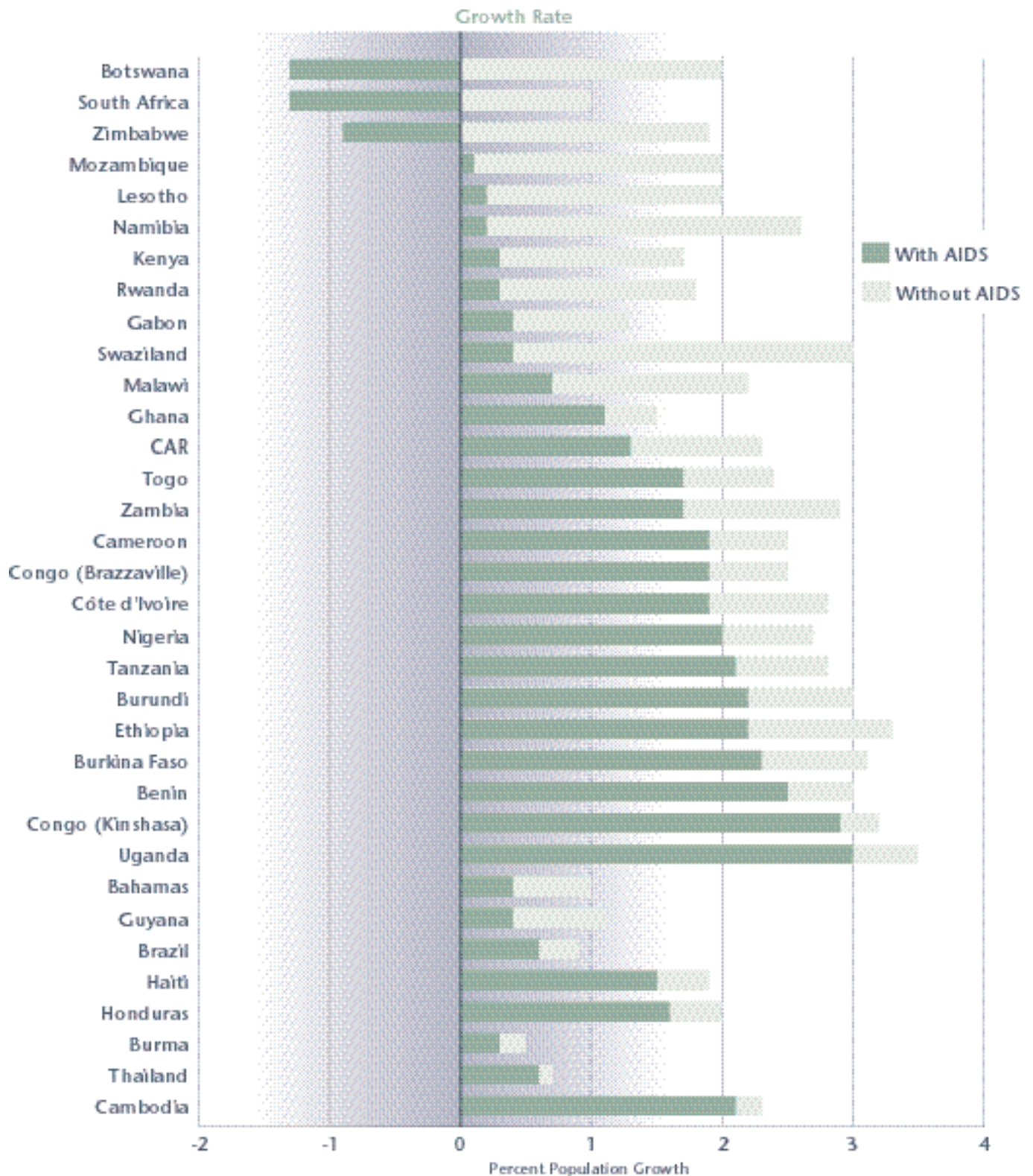
**Life Expectancy at Birth (years),  
With and Without AIDS**



Source: U.S. Bureau of the Census, 2000



By 2010, Botswana, South Africa and Zimbabwe will all be experiencing negative population growth



Source: U.S. Bureau of the Census, International Data Base.

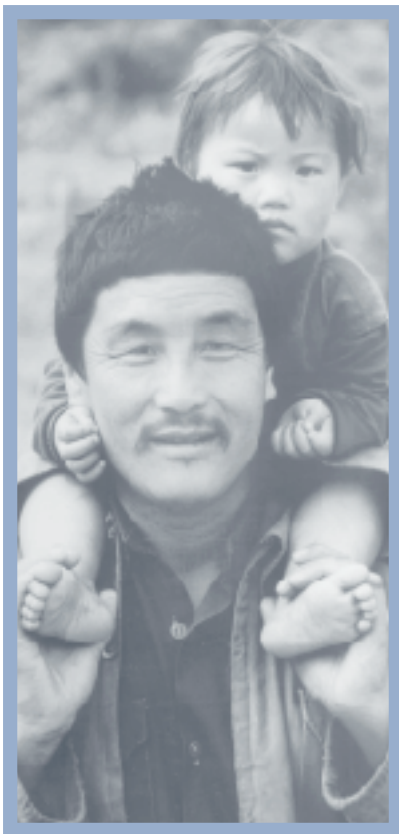


Photo: United Nations

only as a result of increased health care costs, but also from the burial fees they pay and the costs associated with recruiting and training replacement employees. The factors contributing to reduced revenue include time employees spend away from the job because of their own illnesses, attending funerals, or going to training. Because of high turnover, the staff may be relatively inexperienced and therefore less productive. Jobs requiring high levels of skill, education, or experience may go vacant for long periods of time if suitable workers cannot be found. Some firms have estimated that such high AIDS-related costs could reduce profits by 6 to 8 percent annually and productivity by 5 percent.

The transport and mining

sectors—both of which involve workers living far from their families for extended periods of time—are particularly vulnerable. Building and maintaining transport infrastructure throughout the country; driving long-distance buses, trains, and trucks; and mining in remote sites tend to increase the likelihood of multiple sexual partners (and also the possibility of later bringing any acquired infections home to their spouses). High rates of infection in these sectors threaten the viability of these crucial industries and could be important factors in the further spread of HIV, making workplace prevention measures particularly important. According to UNAIDS, one-third of miners in southern Africa in their late 20s and 30s were found to be HIV-infected in 1999. HIV infection rates tend to be higher and are increasing among unskilled workers. When highly trained professionals (e.g., engineers, managers) become infected, they can be difficult to replace in countries that have relatively few skilled professionals.

#### *Burdens on the Education Sector*

Education equips people to make better choices, partly because they have expanded life

options. Thus education helps to protect a society from the spread of HIV. Yet, in many countries, high HIV prevalence is undermining education in several ways. Although the rate of new infection is declining among professionals, the supply of teachers is shrinking as a result of AIDS-related illness and death. Swaziland, for example, estimates that it will need to train more than twice as many teachers as usual in the next 17 years just to maintain its 1997 level of service. The cost of sickness and death benefits for teachers, plus the extra cost of hiring and training new teachers, is expected to exceed U.S. \$200 million by 2016—more than the 1998/99 government of Swaziland budget for all goods and services.

*In Swaziland, the cost of sickness and death benefits for teachers, plus the extra cost of hiring and training new teachers, is expected to exceed U.S. \$200 million by 2016—more than the government's budget for all goods and services for one year.*

HIV/AIDS is also reducing the number of children in school. The death of HIV-infected women during their childbearing years leads to fewer births, and thus, fewer children. Up to one-third of the children they do have are HIV-infected and do not survive to

school age. Healthy children may have to leave school, either temporarily or permanently, to care for sick family members, work in the field, seek income-earning employment, or



simply because their families can no longer afford the fees. Finally, because teenagers are particularly susceptible to acquiring HIV, the education system faces the special challenge of educating students about AIDS and helping them to protect themselves.

### *Reduced Economic Growth*

Analysts agree that it is difficult to estimate the effect of HIV/AIDS on a country's macroeconomy. Too many factors apart from AIDS affect long-term economic growth, including drought, war, corruption, and mismanagement, and projections vary considerably depending upon the assumptions made. Nevertheless, there is growing evidence that high HIV prevalence will have a substantially negative effect on economic growth. Studies in Cameroon, Kenya, Swaziland, Tanzania, Zambia, and other sub-Saharan African countries have found that the rate of growth in gross domestic product could be reduced by as much as 25 percent over a 20-year period. According to estimates by the U.S. National Intelligence Council, economic growth begins to decline at about a 5 percent HIV prevalence level. At 20 percent prevalence levels, the cost is more than 1 percent of gross domestic product annually.

According to UNAIDS, Botswana and South Africa (with a prevalence of 36 percent and 20 percent, respectively) are already experiencing declining



Photo: UNICEF/Charton

economic growth. In Botswana, the expected 1.5 percent annual decline in gross domestic product means that by 2025, the economy will be 31 percent—one-third—smaller than it would have been if it were not for HIV/AIDS. At the same time, health spending may triple. Although there will be some savings in education costs because of the smaller number of children attending school, these savings will be more than overtaken by the added costs of training enough teachers to replace those dying from HIV/AIDS. In addition, even though the economy is shrinking, the need for government spending on social services will increase.

### **Impact on National Security**

In many of the countries hardest hit by AIDS, worsening economic, social and political trends contribute to instability across all sectors and increase the potential for violent conflict,

ethnic unrest, and migration. Unfortunately, where the AIDS crisis is most severe, governing institutions and civil society tend to be weak. AIDS undermines the ability of governments to respond to the crisis by reducing productivity and human capacity in key sectors — civil service technicians, teachers, health workers and the military, for example — and by increasing public costs for health benefits, pensions, and worker recruitment and training.

Military forces, the formal structure of state security, consistently rank among the groups most affected by HIV/AIDS. Some African militaries harbor infection rates up to five times higher than that of the general population; the resulting inefficiencies and lack of discipline have clear national security consequences. The blight of HIV/AIDS in a national military can easily be compounded by fragile governance institutions and econom-

## Leading Causes of Death Globally, 1999

Rank		% of Total
1	Ischaemic heart disease	12.7
2	Cerebrovascular disease	9.9
3	Acute lower respiratory infections	7.1
4	<b>HIV/AIDS</b>	4.8
5	Chronic obstructive pulmonary disease	4.8

Source: *The World Health Report 2000, WHO*

## Leading Causes of Death In Africa, 1999

Rank		% of Total
1	<b>HIV/AIDS</b>	20.6
2	Acute lower respiratory infections	10.3
3	Malaria	9.1
4	Diarrhoeal diseases	7.3
5	Perinatal conditions	5.9

Source: *The World Health Report 2000, WHO*

ic reversals, and lead to instability and internal and external conflict. On a more personal level, African soldiers may be more likely than civilians to engage to risk-taking behaviors, and are a key transmitter group to the general population.

One of the most insidious outcomes of the AIDS pandemic is a large cohort of youth who struggle to survive without family support, without education, without employment opportunities, and carrying a strong sense of despair. This fatalism makes young people especially vulnerable to recruitment by corrupt armies, militias or criminal organizations in many developing countries, destabilizing the security structure even further.

## *The USAID Response*

The United States has been the global leader in addressing HIV/AIDS in developing countries since 1986, when it first undertook HIV/AIDS prevention programming. It is the largest bilateral donor of HIV/AIDS assistance, providing nearly 50 percent of all international HIV/AIDS funding—more than \$1.6 billion since 1986. Although USAID was initially the only U.S. government agency providing international assistance on HIV/AIDS, as funding has expanded, other agencies—including the Centers for Disease Control and Prevention, the Departments of Health and Human Services, Defense and Labor, and the National Institutes of Health—have also become engaged. With its established relationships and expertise in working in

developing countries, USAID is the lead agency on international HIV/AIDS, coordinating the U.S. government response.

USAID's current response to the pandemic builds on a proven track record, established relationships, and a history of technical leadership. It consolidates and scales up lessons learned in 15 years of addressing HIV/AIDS in developing countries, while simultaneously developing and incorporating new and promising strategies in prevention, care and support, and research.

Preventing further HIV transmission and mitigating the effects of AIDS are essential to meeting USAID's broader goals of increasing economic growth, decreasing poverty, increasing agricultural productivity to reduce hunger, and protecting

human health. In high prevalence areas, continued development progress cannot occur if this issue is not addressed; in low prevalence areas, prevention efforts are needed to ensure that HIV/AIDS rates remain low and do not threaten development.

USAID's organizational structure—designed to foster both functional and geographic specialization—helps to make it an effective international actor on complex issues such as HIV/AIDS, providing research and technical leadership and promoting cooperation among a wide range of partners. USAID *country missions* work with host countries to develop programs using the strategies and interventions developed through USAID's Washington offices, and collaborate with the *Regional Bureaus*.



Photo: Panos Pictures

The HIV/AIDS Division in USAID's Washington offices supports multilateral organizations, develops and tests key interventions, provides technical leadership, conducts research, and collaborates with key partners in designing programs. Four *Regional Bureaus* analyze the HIV/AIDS situation in their regions and design, implement, and monitor appropriate interventions for their regions drawing on the technical expertise of the HIV/AIDS Division.

As the United States expands its commitment to addressing the HIV/AIDS pandemic, USAID is well situated to continue its leadership role both within the U.S. government and internationally. USAID's efforts have made a difference by:

- ⊙ Helping more than 35 million vulnerable persons protect themselves and their

families from HIV through intensive programs that have reached them directly with the prevention programs.

- ⊙ Increasing global knowledge of the nature, magnitude, and impact of the pandemic. USAID has produced and disseminated key policy documents such as the 1997 and 2000 editions of *Children on the Brink*, which reported new estimates of orphans in developing countries and garnered international attention to the plight of children affected by HIV/AIDS. Another USAID-supported U.S. Bureau of the Census report on the demographic impact of AIDS, including recently projected negative population growth in some developing countries, served to alert the public of the dis-

ease's reach beyond the health sector.

- ⊙ Identifying, testing, and implementing pragmatic, field-tested approaches to HIV/AIDS care and support for orphans and other children affected by HIV/AIDS.
- ⊙ Sharing U.S. expertise, resources, and products. USAID is one of the largest suppliers of condoms in the world. Research in developing countries has shown that good-quality condoms work well if used consistently.
- ⊙ Leveraging other donor and private funding and other support. In Zambia, for example, a private South African firm, Sasol, which imports large quantities of fertilizer, has printed an easy-to-read HIV prevention message on 800,000 fertilizer bags.

## History of U.S. Response

Initially, the USAID strategy focused almost exclusively on prevention. With no effective or affordable cure available, the United States and other donors believe that resources could most effectively be focused on protecting people from acquiring HIV infection. From the mid-1980s to the mid-1990s, USAID developed and promoted a number of strategies to prevent new infections in the most at-risk populations. That experience taught us a number of



lessons that have proven highly effective in the evolving U.S. and international response.

- ⊙ Highly focused, well-targeted prevention efforts can significantly reduce the rate of HIV transmission.
- ⊙ No single, standardized set of interventions will work in all settings.
- ⊙ To be effective, prevention efforts need to be accompanied by care, treatment, and support interventions to mitigate the effects for individuals, families, and communities already affected by the virus.

### **Building on Lessons Learned**

In the mid-1990s, with the epidemic accelerating at an ever-faster pace, USAID recognized a need to consolidate the lessons that had been learned in small-scale projects, develop new strategies, increase funding levels, and apply lessons learned and tools developed on a larger scale. Therefore, USAID undertook a comprehensive review of its HIV/AIDS strategy that ultimately led to a thorough redesign of its program. Consistent with USAID principles, the redesign process relied on active participation by all who had a stake in the outcome—including developing country health ministries and AIDS control agencies, policy-makers, private voluntary organizations, nongovernmental organizations, organizations representing people living with HIV/AIDS, other international

donors, and various U.S. government agencies.

The redesign process led to a broadly shared understanding of what form an ideal response to the changing pandemic would take, and what the most effective role for USAID would be. It produced the following two-pronged strategy that continues to guide USAID's evolving and expanding program:

- ⊙ Expand the emphasis on sustainable approaches to preventing HIV transmission. Approximately 70 percent of USAID's HIV/AIDS budget continues to be allocated for prevention; and
- ⊙ Develop new activities to provide care, treatment, and support for people and communities coping with HIV/AIDS and apply research findings to mitigate the epidemic's social and economic impact.

### **Leadership and Investment in Fighting an Epidemic**

In 1999, the United States launched a new government-wide initiative in the battle against AIDS. Leadership and Investment in Fighting an Epidemic (LIFE) provided an additional \$100 million in 2000 for the global fight against HIV/AIDS, enhanced U.S. leadership in this area, and made more resources available to developing countries through such measures as debt relief and concessional loans. As a result, the United States has been able

to leverage additional resources from other donor countries as well as from other sectors to step up global mobilization against AIDS.

LIFE funding—approximately one-half of which went to USAID—enabled USAID to step up its HIV/AIDS prevention and mitigation efforts in 13 countries (12 in sub-Saharan Africa plus India). It brought USAID's HIV/AIDS budget to \$200 million for 2000.

### **Expanded Response**

In 2001, the United States expanded its response to the HIV/AIDS pandemic, with USAID coordinating the effort both within the U.S. government and with other donors.

USAID's "expanded response" is designed to enhance the capacity of developing countries to prevent an increase in HIV/AIDS and provide services to those who are either infected and or otherwise affected by the epidemic (orphans, vulnerable children, and other family members). Toward these ends, USAID is strengthening its financial and technical support to selected "high prevalence" and "low prevalence" countries. High prevalence countries are defined as those where more than 1 percent of the adult population (ages 15 to 49) is infected with HIV. Low prevalence countries receiving assistance have a less than 1 percent infection rate but show trend data and levels of risk behaviors that suggest their infection rate could accelerate.



The “expanded response” supports the following goals for global action by 2007:

- ⊙ Reduce HIV prevalence among 15- to 24-year-olds by 50 percent in high prevalence countries.
- ⊙ Maintain prevalence below 1 percent among 15- to 49-year-olds in low prevalence countries.
- ⊙ Ensure that at least 25 percent of HIV-positive mothers in high prevalence countries have access to interventions to reduce HIV transmission to their infants.
- ⊙ Ensure that countries can provide basic care and psychosocial support service to at least 25 percent of HIV-infected persons in high prevalence countries, and provide community support services to at least 25 percent of children affected by HIV/AIDS in high prevalence countries.

The specific targets within these ranges and the precise number of countries involved will depend upon actual funding levels in the years ahead. The targets will be reviewed regularly in light of new data and ongoing analyses of cost-effectiveness and HIV prevalence. USAID is collaborating with the Centers for Disease Control and Prevention, the World Health Organization, and UNAIDS to improve surveillance systems, and will undertake periodic national surveys to collect information on changes in sexual behavior and to measure the

quality and coverage of care and support services.

## USAID's Current HIV/AIDS Strategy

Today USAID's HIV/AIDS program is multifaceted and includes the following major approaches:

- ⊙ Preventing the transmission of HIV;
- ⊙ Providing care and treatment to individuals and communities affected by HIV/AIDS;
- ⊙ Addressing the needs of orphans and vulnerable children;
- ⊙ Increasing national and international surveillance capacity;
- ⊙ Increasing health systems capacity;
- ⊙ Providing technical leadership through research;
- ⊙ Working in partnership with donors, national governments, and community groups; and
- ⊙ Creating an environment that supports HIV/AIDS prevention and care.

### Preventing New Infections

Preventing new HIV infections continues to be the most urgent priority in the fight against HIV/AIDS in both high prevalence and low prevalence countries. Prevention activities are aimed at slowing—and ultimately reversing—rising HIV infection rates. In developing countries, 90 percent of new infections result from either sexual

transmission (80 percent) or mother-to-child transmission (10 percent). Another 5 percent result from blood contact (either through transfusion of contaminated blood or through infected needles).

USAID's approach to prevention is to reduce the risk factors that contribute to HIV transmission through:

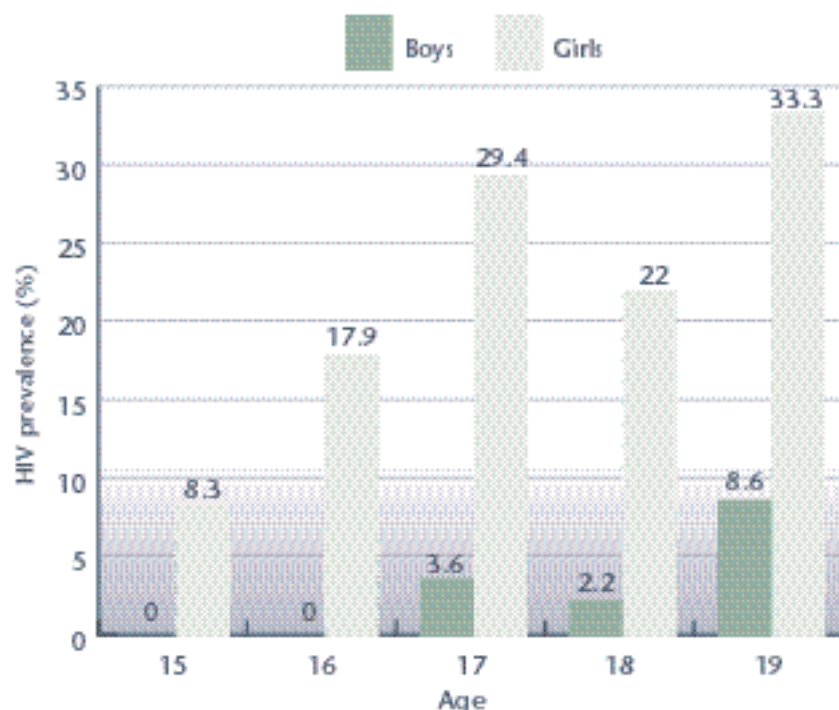
- ⊙ Developing interventions to change high-risk sexual behavior;
- ⊙ Treating other sexually transmitted infections;
- ⊙ Increasing demand for and access to condoms and other essential commodities;
- ⊙ Preventing mother-to-child transmission of HIV; and
- ⊙ Promoting voluntary HIV counseling and testing.

Preventing the spread of HIV/AIDS among young people is of particular importance to USAID; half of all new HIV infections occur among 15- to 24-year-olds.

Efforts focusing on HIV prevention—particularly those that combine multiple approaches—have yielded some clear successes:

*Uganda* is a developing world model for curbing the spread of HIV/AIDS. With strong leadership from its president and aggressive prevention and care programs, it reduced national HIV prevalence by 50 percent between 1992 and 1999, and by one-third among young women

## HIV Prevalence Rate Among Teenagers in Kismu, Kenya, By Age



Source: National AIDS Programme, Kenya, and Population Council, 1999

(aged 15 to 24). HIV incidence and prevalence among 15- to 19-year-olds in urban areas have also declined, likely due to delayed onset of sexual activity. An array of USAID-supported interventions contributed to these successes, including voluntary counseling and testing, training volunteers to provide basic counseling and nursing services, primary education support for AIDS orphans, workplace prevention education, subsidized condom sales, and HIV/AIDS education and awareness programs for religious leaders and Muslim youth enrolled in religious school.

In *Thailand*, when it became apparent in the late 1980s that HIV/AIDS was exploding among injecting drug users and sex workers, the government

implemented a policy requiring 100 percent condom use in commercial brothels and succeeded in reducing HIV infection rates among military recruits by half. Launched through a nationwide public information campaign and enforced by brothel owners, local police, and health clinics, the policy increased condom use to more than 90 percent. This is widely viewed as an excellent example of how swift and decisive action can arrest the epidemic.

In *Cambodia*, HIV prevalence dropped from 3.9 percent of adults in 1997 to 2.8 percent of adults in 2000. This decline can be attributed in part to a reduction in new infections among groups at high risk and implementation of a 100% condom

use policy in commercial sex establishments. The rate of HIV infection among sex workers below 20 years of age dropped from more than 40 percent in 1998 to 23 percent in 2000.

*Zambia* has been able to reduce HIV prevalence among 15- to 19-year-olds by 42 percent, while condom use among all age groups in urban areas jumped from 36 percent in 1996 to 48 percent in 1999. Declining prevalence has been attributed to behavior change through delay in the onset of sexual activity and more consistent condom use among youth. A USAID-sponsored mass media campaign aimed at young adults contributed to these trends.

### Communicating About Behavior Change

USAID has focused much of its prevention effort on developing, implementing, and monitoring communications strategies to reach specific populations at high risk as well as the general population with appropriate messages. How well the language, content, tone, and style of the message is geared to a particular audience will determine a communication campaign's success. The most effective programs deliver a consistent message through multiple, mutually reinforcing channels (newspaper, radio, billboards, community theater). Research also shows that involving individuals from the particular target community—sex workers, for example—in delivering the

message gives credibility, reduces fear and stigma, and makes it more likely that people hearing the message will follow through with specific behaviors, such as using condoms or getting tested for infection.

One USAID-supported program in Kenya grew from 35 youth theater groups in 1995 to more than 270 groups by 2000, reaching more than 400,000 people with performances that encourage behavior changes and stimulate thought-provoking discussions about the epidemic. The theater groups have popularized the “ABCs” of safe sex—Abstinence, Be Faithful, and Use Condoms—among young people.

### *Ensuring Access to and Use of Condoms and Other Essential Commodities*

USAID has been a leader in promoting the use of condoms to combat HIV/AIDS, both by distributing them directly—close to 364 mil-

lion in 2000 alone—and by developing messages that succeed in getting people to use them.

Condom social marketing is a particularly powerful tool that uses private sector advertising and commercial distribution to make condoms more widely accessible and promote behavior change. USAID support for condom social marketing has significantly

*It is estimated that distribution of approximately 300 million condoms can avert up to half a million new HIV infections yearly.*

increased condom sales and use where applied. It is estimated that distribution of approximately 300 million condoms can avert up to half a million new HIV infections yearly. In Haiti, for example, cumulative sales of the USAID-supported *Pante* condom reached almost 60 million by the end of 2000. More than 75 percent of sexually active Haitians are aware of the *Pante* condom brand and of the protection provided by condoms against HIV/AIDS.

In addition to condom social marketing, USAID is developing new approaches to procuring and delivering other commodities that can make a real difference in preventing HIV transmission and treating and caring for people living with HIV/AIDS. In many developing nations, the majority of people do not have access to condoms or other commodities

## Risk Populations

- **Commercial sex workers and their clients**
- **Male migrant workers (e.g. truckers, construction workers, seafarers)**
- **Military/police**
- **Civil servants**
- **Men who have sex with men**
- **Injecting drug users**
- **Patients with sexually transmitted infections**
- **Youth, single women**

Source: USAID

necessary for preventing and treating HIV and other sexually transmitted infections; testing services to determine HIV status; drugs for palliative care of opportunistic infections, including tuberculosis; and gloves, sterilization equipment, and other items needed to safeguard both patients and health care personnel.

### *Treating and Controlling Sexually Transmitted Infections*

Researchers have found that the presence of other sexually transmitted infections greatly increases the likelihood of acquiring HIV. In regions where untreated sexually transmitted infections are endemic (for example, sub-Saharan Africa), preventing and managing such infections is an important strategy for preventing the spread of HIV/AIDS. However, many factors make designing and implementing infection prevention and control programs difficult. The stigma surrounding sexually transmitted infections makes people reluctant to seek treat-

ment, and limited national health budgets mean that infection prevention and treatment is often not a national priority. Individuals may be too poor to pay for treatment even if they want it, and in many areas with weak health infrastructures, infection prevention and control programs may simply not exist.

USAID has developed a number of innovative strategies to overcome these problems, and now its focus is on designing programs that combine these strategies in unique ways depending upon the particular setting. Effective strategies include:

- ⊙ Treating all people in a particular group without individually diagnosing which specific individuals are infected. This approach can be used with groups known to engage in high-risk behaviors or with the general population.
- ⊙ Treating a patient for all likely causes of a symptom of a sexually transmitted infection, without determining the specific cause of the symptom. In one Tanzanian city, this approach led to a 42 percent reduction in new HIV cases.
- ⊙ Training individuals to be peer educators within their group. For example, in the

Dominican Republic, South Africa, Zambia, and Zimbabwe, sex workers have been trained to provide peer counseling on sexually transmitted infections and HIV.

Because the sexually transmitted infection and HIV epidemics are complex and involve intensely personal behavior, it is not possible to apply

*In East and southern Africa, infant mortality rates today are nearly 70 percent higher than they would have been without AIDS.*

simple solutions. But evidence is mounting that interventions used in the appropriate combinations for the particular settings and populations involved can reduce transmission of both HIV and other sexually transmitted infections. USAID is currently studying various combinations of approaches in small trials in a variety of settings.

### *Preventing Mother-to-Child Transmission*

The vast majority of children with HIV contract it through their mothers via mother-to-

child transmission. Mother-to-child transmission takes place in three ways: during pregnancy, during delivery, or through breastfeeding. It is currently estimated to be the cause of about 10 percent of all new HIV infections.

Mother-to-child transmission has already dramatically affected overall child health and survival in many countries, and is seriously undermining the substantial gains in child health made over the last few years through a range of programs supported by USAID and other donors. In East and Southern Africa, infant mortality rates today are nearly 70 percent higher than they would have been without AIDS. As a result, life expectancy is falling, and could be as low as 30 years in some countries by the end of the decade.

The most effective way to prevent mother-to-child transmission is, of course, to prevent women of reproductive age from becoming infected with HIV. However, for the millions of women around the world already infected and for those who will become infected, a

## How is HIV Transmitted?

Type of exposure	Percent of global total
Blood transfusion	5%
Mother-to-child transmission	10%
Sexual intercourse	80%
Injecting drug use	5%
Health care	.01%

Source: USAID





Photo: Rich Marchewka

group of interventions is now available to help protect their infants. USAID-supported pilot studies have demonstrated the value of some key interventions:

- ⦿ Improving antenatal services;
- ⦿ Introducing voluntary, confidential counseling and testing services;
- ⦿ Offering short-course antiretroviral prophylactic treatment to HIV-positive pregnant women;
- ⦿ Counseling and supporting women to undertake safe infant feeding practices; and
- ⦿ Strengthening health, family planning, and safe motherhood programs.

These interventions appear to be effective and sustainable. Further research and the addition of more countries, combined with collaboration with

other partners, will expand their reach still further. In addition to preventing mother-to-child transmission of HIV, by improving prenatal, delivery, and postpartum care, these interventions also improve the overall health of mothers and children.

### *Voluntary Counseling and Testing*

Voluntary counseling and testing is an important new tool in HIV prevention, one that has moved to the forefront of HIV/AIDS programming in developing countries largely through USAID-funded research and services. In addition to promoting less risky behavior among both infected and uninfected individuals, voluntary counseling and testing is the portal to a range of care and support services, including interventions to reduce mother-to-child transmission. It also helps to overcome the stigma associated with HIV/AIDS.

A collaborative, multisite study in Kenya, Tanzania, and Trinidad and Tobago showed that voluntary counseling and testing can reduce risky sexual behavior, especially in persons infected with HIV. The study demonstrated that this critical service could be provided at \$12 to \$17 per client, well within the range of other core public health services.

USAID's consistent support of \$1 million per year throughout the 1990s to Uganda's HIV/AIDS Information Center is credited with a key role in the "Uganda success story." After building the basic package of reliable testing in the context of high-quality, client-centered counseling, USAID partners have developed refinements—such as community counseling and referral, and the use of rapid HIV tests to provide "same day results"—that increase the reach and effect of voluntary counseling and testing. Today, more than a dozen USAID programs in Asia and Africa have adopted voluntary counseling and testing as one of their core interventions. Studies in Kenya and Uganda are exploring how to expand voluntary testing among young people after earlier studies demonstrated that effective counseling helps to reduce HIV infection in youth.

### **Providing Care and Treatment**

HIV/AIDS is an enduring epidemic, and must therefore be fought in multiple ways. Prevention activities remain



USAID's primary focus, but with the accumulation of experience, improved data about the extent of the epidemic in various societies, and the "maturing" of the epidemic, it is now clear that prevention activities are more successful when accompanied by care and treatment for those already affected. The fight against HIV/AIDS therefore includes providing care for those who are ill, both for humanitarian reasons and because prevention efforts work best when they have the trust of those who are already ill or are among those most likely to become infected.

Caring for and treating those already affected by HIV/AIDS cannot be separated from the goal of preventing further transmission. Availability of care:

- ◎ ***Reinforces HIV prevention.*** Many prevention measures are specifically related to the availability of care: treating sexually transmitted infections requires health care services, HIV voluntary testing requires the ability to refer HIV-infected individuals for health services, and changing sexual behavior is much easier in the context of a wider range of health services.
- ◎ ***Provides hope to those who have or fear they may have HIV/AIDS.*** Availability of care signals to people that they will not be abandoned if they are HIV-infected, making them more willing to get tested and to use con-

doms and other prevention measures.

- ◎ ***Destigmatizes HIV/AIDS.*** When care for HIV/AIDS is available in the community, the community can no longer deny the reality of HIV/AIDS. It gives a face to the epidemic, and helps others to understand their own risks. Patients with HIV/AIDS who are able to speak out without fear of prejudice or discrimination are effective voices on behalf of prevention.
- ◎ ***Stabilizes communities.*** In communities already affected by generalized epidemics, families and the community may be overwhelmed by the impact of the disease. Care and treatment can prolong life, reduce physical discomfort, and improve the emotional well-being and coping mechanisms of patients and their families, enabling them to remain productive.

Prevention, care, and support constitute a continuum of interventions that are needed individually or in tandem, depending upon the specific context. Care involves services to stabilize or elevate the physical or mental health of persons infected or affected by HIV and AIDS. Support involves interventions to stabilize or improve community and societal systems affected by the pandemic (e.g., strengthened health systems, economic support to communities hard hit by HIV/AIDS,

## Essential Technical Elements of an HIV/AIDS Program

### Prevention

- Blood safety
- Universal precautions in clinical settings
- Sexual risk reduction
- Condom distribution and marketing
- Harm reduction for injecting drug users
- Management of sexually transmitted infections
- Voluntary counseling and testing
- Prevention of mother-to-child transmission
- Surveillance/monitoring and evaluation

### Care and Mitigation

- Palliative care
- Psychosocial support
- Treatment of opportunistic infections, including tuberculosis
- Support for children affected by HIV/AIDS
- AIDS care (antiretroviral therapy)

### Creating an Enabling Environment

- Stigma reduction
- Promotion of human rights
- Greater involvement of people living with HIV/AIDS
- Policy dialogue/advocacy
- Multisectoral engagement
- Human and institutional capacity development

Source: USAID



Photo: U.S. Agency for International Development/Griffite, Davis

efforts to strengthen human rights). Together, this continuum of interventions reduces the impact of HIV/AIDS on individuals, families, communities, and nations.

USAID's care and treatment interventions include:

- ⊙ Care and treatment of opportunistic infections associated with HIV/AIDS, especially tuberculosis;
- ⊙ Psychosocial care of persons infected with and affected by HIV/AIDS;
- ⊙ Palliative care for persons with HIV-related symptoms such as pain, fever, or diarrhea; and

- ⊙ Introductory programs to explore the potential of antiretroviral drugs in the context of limited health resources.

### *Treating Tuberculosis and Other Infections*

HIV and tuberculosis are the two biggest infectious killers in the world today. Thirty-six million people are HIV/AIDS-infected, and 2 billion people are infected with tuberculosis. Almost one-third of those with HIV infection are also infected with tuberculosis. Just as HIV accelerates progression of tuberculosis infection to tuberculosis disease (people with HIV and tuberculosis are 30 times more likely to get active tuberculosis

disease), recent studies have shown that infection with tuberculosis enhances replication of HIV and will accelerate the progression of HIV infection to AIDS. Luckily, tuberculosis treatment for patients with HIV is as effective as for those who are not infected with HIV. In addition, clinical trials have shown that prophylactic use of antituberculosis drugs can prevent active tuberculosis in HIV-infected persons.

The dual epidemics of tuberculosis and HIV are particularly pervasive in Africa where more than 50 percent of patients with tuberculosis (individuals with active tuberculosis disease) are also infected with HIV. The dual epidemics are now also of growing concern in Asia, where two-thirds of tuberculosis-infected people live, and in the former Soviet states, where the HIV epidemic is growing and multiple drug-resistant strains of tuberculosis are most common. Prevention and treatment of active tuberculosis in HIV-infected individuals is one of the most important interventions designed to increase the length and quality of life of those infected, and to benefit families and communities affected by HIV.

USAID is committed to addressing the global burden of tuberculosis in close collaboration with local and global partners. Its goal is to make a significant contribution to the global effort to prevent and control tuberculosis, leading to a reduction in the morbidity and mor-

tality associated with the disease. USAID's strategy for tuberculosis focuses on four areas:

- ⊙ Expanding programs in key countries, concentrating on expanding the introduction and implementation of the highly effective Directly Observed Treatment, Short Course (DOTS) strategy, which has a potential success rate of 80 percent of cases.
- ⊙ Continuing to invest in global and regional partnerships, including the global Stop TB Initiative; and intense collaboration with the World Health Organization, U.S. government agencies, including the Centers for Disease Control and Prevention and the National Institutes of Health, The Global Partnership to develop new antituberculosis drugs, the Global Drug Facility to ensure availability of quality antituberculosis drugs, and a new international coalition to provide extensive technical assistance to tuberculosis programs in developing countries.
- ⊙ Investment in expanding the cadre of tuberculosis experts in the developing and developed world to address one of the key limiting factors to improving the control of tuberculosis.
- ⊙ Expanded research investments, particularly the development of rapid, low-cost diagnostics appropriate for low-income countries, cost-

effective new tuberculosis drugs and combination therapies, and improved approaches to implementing DOTS and other tuberculosis control strategies.

### *Antiretroviral Drugs*

Over the past three years, the growing availability and declining cost of antiretroviral drugs to treat AIDS have given new hope to those living with the disease, and have led the global community to expand the concept of a comprehensive response to the pandemic.

USAID currently funds 25 care and treatment projects in 14 countries. Introductory programs using antiretroviral treatment to reduce mother-to-child transmission of HIV are currently underway in Zambia and Kenya, with additional activities

planned for Uganda, Malawi, Rwanda, and South Africa.

A number of challenges continue to hamper efforts to scale up HIV/AIDS care services in some developing nations, including the higher cost of antiretroviral treatment relative to prevention programs and tenuous health care infrastructures. Treatment of AIDS symptoms and opportunistic infections, together with ensuring access to fundamental needs, like food and schooling, must also be addressed. USAID's position is that effective antiretroviral treatment programs will require the following components:

- ⊙ A sustainable supply of drugs;
- ⊙ Sufficient infrastructure to use antiretroviral drugs, including basic laboratory and drug management systems;



Photo: UNICEF/Haskell



## Kenya: Making the Prevention-to-Care Continuum Work

In Kenya, where the adult HIV infection rate is 14 percent and the epidemic continues to spread unchecked, the need for strengthening the prevention-to-care continuum is acute. Family Health International/IMPACT, funded by USAID, has successfully incorporated this approach into its activities in 11 Kenyan communities, partnering with 22 nongovernmental organizations and the Kenyan government to design interventions that respond to specific community needs.

The IMPACT program in Kenya seeks to promote behavior change, improve the social environment to reduce the risk of HIV transmission, and provide HIV/AIDS-related services, such as accessible diagnosis and treatment of sexually transmitted infections and voluntary HIV counseling and testing. Peer educators and outreach workers—who participate in one-week IMPACT-sponsored training sessions—provide HIV/AIDS education, sexually transmitted infection treatment referral, and voluntary HIV counseling and testing referral to groups at risk for HIV infection, such as sex workers and youth.

IMPACT sees voluntary counseling and testing centers as the key to linking prevention and care, and has begun to establish a network of 12 of these centers across Kenya to provide HIV-positive clients with psychological and social support, and information on care, diagnosis, and treatment of opportunistic infections common in those living with AIDS. Previously, services were virtually nonexistent in Kenya; in 1999, only one site in Nairobi offered walk-in voluntary counseling and testing services.

Using community-based participatory assessment tools, IMPACT is working with Kenya's District AIDS Committees and a local nongovernmental organization, the International Community for Relief of Starvation and Suffering, to identify the needs of families affected by HIV/AIDS and respond via home care teams of government health care providers and volunteers. In addition, IMPACT is working with the Kenyan Ministry of Health to strengthen the capacity of medical facilities to diagnose and treat tuberculosis and prepare government health centers to serve as HIV clinical care centers.

- ◉ Equitable and ethical access to treatment;
- ◉ Expansion of voluntary counseling and testing services as an entry point to care;
- ◉ Involvement of persons living with HIV/AIDS in program planning; and
- ◉ Strengthening of existing HIV/AIDS prevention programs.

Despite the obstacles, USAID is committed to incorporating antiretroviral drug therapy into care and treatment programs where feasible. USAID is finalizing selection of a number of introductory sites for such

treatment programs, to be launched in late 2001. The sites will provide valuable lessons about how to safely and effectively deliver drugs to treat AIDS and how to build capacity to expand access to treatment.

### *Psychosocial and Palliative Care*

For the vast majority of people living with HIV/AIDS who do not have access to drug treatment, psychosocial and palliative care can go a long way toward improving quality of life. Psychological support can help infected individuals cope with the implications of having a life-threatening disease, while social support can alleviate the eco-

nomic loss and stigma attached to the disease. In addition, symptomatic care can ease some of the physical discomfort that accompanies HIV/AIDS.

In 1997, USAID, as part of its revised HIV/AIDS strategy, placed new emphasis on supporting programs providing care and support to persons infected and affected by HIV/AIDS. The AIDS Support Organization in Uganda, which covers vocational and school fees for children affected by HIV/AIDS, helps both parents and children plan for the consequences of a death due to AIDS, and trains teachers in basic HIV/AIDS counseling skills. This care and support



model is being replicated in Kenya, Nigeria, Tanzania, and Zambia.

### **Addressing the Needs of Orphans and Vulnerable Children**

One of the most tragic consequences of HIV/AIDS is its devastating impact on the emotional and physical health and well-being of children. Affected are both those who contract HIV/AIDS themselves and the millions of children throughout the developing world whose lives are radically altered when their parents get sick and die. AIDS has orphaned approximately 13.2 million children under age 15 (i.e., they have lost their mother or both parents) since the pandemic began. According to USAID's *Children on the Brink 2000* report, more than 44 million children in 34 developing countries will have lost one or both parents by 2010. Most of these deaths will result from AIDS.

The impact on so many orphans and other vulnerable children is substantial—for the children themselves, the families that step in to care for them, and the communities in which they live. Not only do children lose the security and safety of their immediate families, they frequently end up taking on adult responsibilities at very early ages. They provide care for ill or dying parents, take over farm and household work, care for younger siblings, and earn money for basic necessities.

They are forced to give up school, have less access to health care, and become vulnerable to malnutrition as family resources dwindle. In sub-Saharan Africa, where most children affected by HIV/AIDS reside, gains in improving child health are quickly unraveling.

Throughout the developing world, nongovernmental organizations are implementing a range of interventions in support of orphans and other vulnerable children. Interventions include establishing volunteer visitor programs; providing material support in the form of food, school fees, shelter, clothing, and blankets; providing counseling and ongoing support; developing community schools and community-based child care; supporting parents in planning for the future care of their children; and reducing stigma and discrimination aimed at persons living with HIV/AIDS and their families. USAID has provided support to such initiatives since 1999. Initiatives in this area provide direct support to community organizations, and at other times build the capacity of local groups to provide improved services to a larger pool of beneficiaries.

In addition to allocating specially marked funds for orphans and vulnerable children, USAID supports HIV-affected children through ongoing programs supported by Title II Food for Peace and basic education funds.

USAID's successes in this area include:

- ⊙ In Uganda, USAID-supported researchers are assessing the impact of a basic orphan support program on the physical, educational, and emotional well-being of children, in addition to a succession planning program for HIV/AIDS-affected families. Information gathered on issues such as family coping mechanisms and the likelihood of property-grabbing upon a family member's death will inform future programs targeting orphans and vulnerable children.
- ⊙ In Zambia, 27 community-based learning centers are using interactive radio instruction and local volunteers to provide affordable, basic education to out-of-school and other vulnerable children. In October 2000, after its first six months of operation, the project reported enrollment of 60 learners per center location for 10 weeks, and 47 per center location for subsequent weeks. Mean gains in language comprehension were between 21.5 and 46 percent.
- ⊙ In Cambodia, a national linking organization for nongovernmental organizations works with 17 local groups to improve their ability to integrate care for orphans and children affected by HIV/AIDS with ongoing prevention activities. The program assists nongovernmental organizations in integrating HIV/AIDS-affected families

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## Building a Better HIV Surveillance System in Cambodia

Cambodia, home to one of the fastest growing HIV/AIDS epidemics in Asia, is attracting increased attention and support from USAID and other international donors eager to curb the disease before it wreaks further damage. The country's HIV prevalence peaked in 1997 at 3.9 percent of the adult population, but dropped to 2.8 percent in 2000. The epidemic, initially concentrated among high-risk groups such as sex workers and the military, now has spread to the general adult population.

Tracking HIV/AIDS through reliable sentinel surveillance will be essential in determining where and how interventions are best implemented in Cambodia. Since 1995, the USAID-supported Family Health International/IMPACT project has assisted the Cambodian National AIDS Program in interpreting existing HIV data, and in strengthening local capacity to conduct HIV surveillance.

Family Health International staff and consultants have worked with Cambodian experts to develop mid-term plans for integrated HIV surveillance, conduct consensus workshops to interpret and disseminate surveillance data, prepare data for presentation at international conferences and journal publication, and enhance data collection systems to improve and adapt to changing needs.

Data coming out of the expanded system have already helped Cambodian officials identify key trouble spots. For example, six of the nine provinces with the highest HIV prevalence among sentinel groups have land and sea borders, and prevalence is particularly high along Cambodia's northwest and southwest borders with Thailand. In one of these provinces, Koh Kong, HIV prevalence was 24 percent among police and 8 percent among women who attended antenatal clinics in 1999. Such findings are critical to Cambodia's national response to the epidemic because remote border areas previously were not targeted for HIV/AIDS education and prevention interventions.

In addition to strengthening sentinel surveillance, Family Health International has supported Cambodia in developing one of the first behavioral surveillance survey systems in Asia. Data from three rounds of the survey show reductions in risk behavior beginning in 1996. One of the most important behaviors tracked in the survey is use of condoms by brothel-based sex workers with their clients. The percentage of sex workers reporting that they always use condoms with their clients has risen steadily, from 42 percent in 1997 to 78 percent in 1999. Sentinel surveillance data show a slight decline in HIV prevalence in this group, as well as a decline in new infections.

Results from both surveillance systems are informing the Cambodia National AIDS Program in devising new strategies for HIV/AIDS prevention as well as for care and support. With data showing a shift in infections from high-risk groups to the general population, programs to prevent mother-to-child transmission and to provide care and support to women and children have become critical components of the national response to HIV/AIDS.

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into community support schemes such as funeral funds and community savings plans.

### Increasing Surveillance Capacity

Early in the pandemic, USAID recognized the importance of collecting surveillance data to track the expanding HIV pan-

demic and to measure the effect of prevention interventions. In 1987, USAID allocated funds to the U.S. Census Bureau to collect HIV surveillance data, analyze it, and provide technical assistance to country programs. The resulting HIV/AIDS Surveillance Database collects widely scattered information

from small scale surveys and studies presented in the medical and scientific literature, at international conferences, and in the press. It compiles and analyzes the information and makes it easily available to countries, donors, nongovernmental organizations, and others. Today, the U.S. Census Bureau is the globally

recognized leader in tracking HIV patterns and trends.

USAID, in collaboration with the Centers for Disease Control and Prevention, also provides assistance to countries in developing their surveillance programs. Surveillance activities are being expanded to better capture a diverse and changing pandemic, increase technical assistance to national surveillance programs, and expand training for developing country epidemiologists and service providers.

In addition, USAID, the World Health Organization, UNAIDS, and other partners are collaborating to implement second generation surveillance systems. These systems aim to improve the quality and ability of existing systems to yield information useful in reducing the spread of HIV and in providing care for those affected by the disease. The goals of second generation surveillance systems are:

- ⊙ Better understanding of trends over time;
- ⊙ Better understanding of the behaviors driving the epidemic in-country;
- ⊙ More focused surveillance on subpopulations at highest risk of infection;
- ⊙ Flexible surveillance that moves with the needs and state of the epidemic; and
- ⊙ Better use of surveillance data to increase understanding and to plan prevention and care.

By concentrating surveillance in areas where it can provide the most information, second-generation surveillance systems ensure that money and expertise are used as efficiently as possible and are tailored to a country's capacity. A central tenet of second generation surveillance is that behavioral and biological surveillance data be used to inform and explain one another. The value of the two sets of information to illuminate real trends in the pandemic, and the behaviors that contribute to it, is greatly increased if they are designed to be used together.

### **Increasing Health Systems Capacity**

In poor countries, HIV/AIDS poses severe challenges to already overstretched health systems. Health systems in many countries have only limited capacity to respond to the many new issues that the emergence of a deadly pandemic raises: how to allocate resources between prevention and care; how to determine overall resource needs and negotiate with policymakers who control budget allocations; how to develop protocols for HIV/AIDS and other health services; how to ensure that

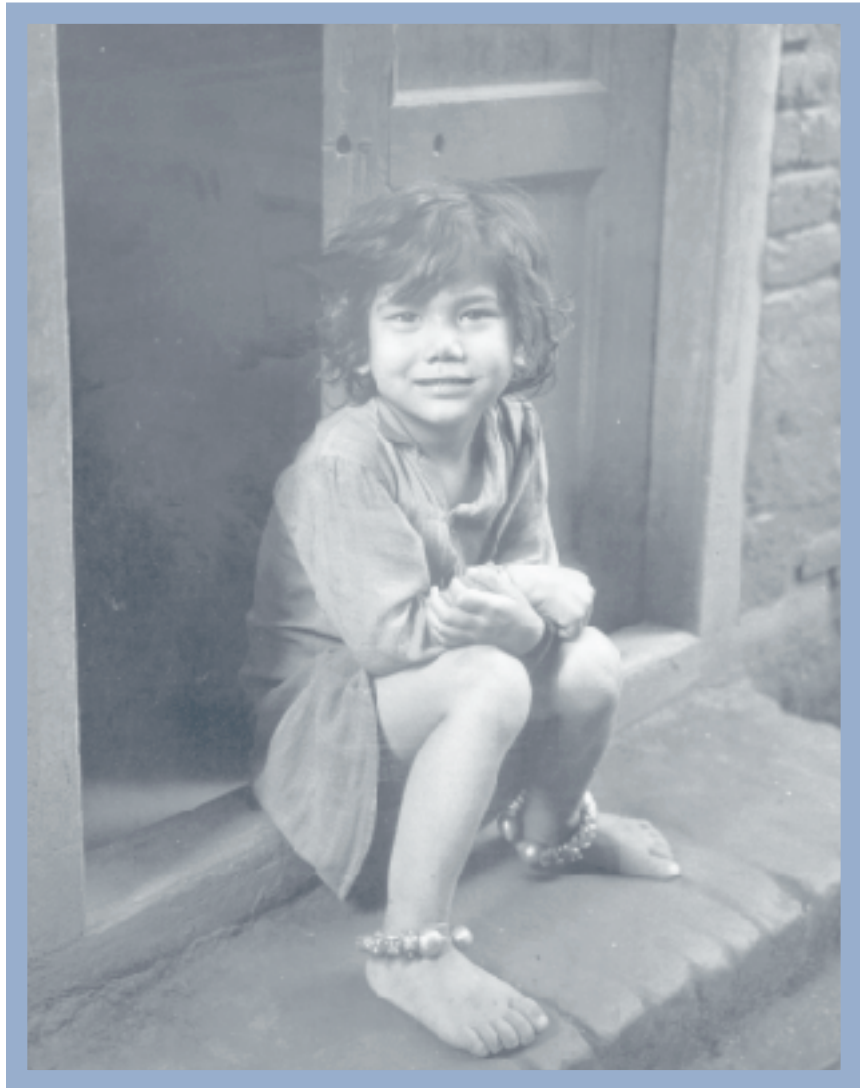


Photo: U.S. Agency for International Development

drugs, staff, and other resources are available; and what human resource policies are needed as health workers themselves become ill, or as needs shift from curing the sick to maintaining quality of life for the chronically ill.

To make the health system better able to respond to the issues posed by HIV/AIDS, countries need to:

- ⦿ Develop guidelines about the kinds of care the system can provide;
- ⦿ Organize support among various kinds of providers to develop these guidelines;
- ⦿ Develop management systems that support prevention and care; and
- ⦿ Regulate private sector care.

USAID is the preeminent world leader in health systems research and development. It has adapted approaches first used in the United States for use in developing countries, and now has an array of tools that can be used to help developing countries address the challenges posed by HIV/AIDS. These include development of national health accounts, which aggregate and track health spending in the public sector; field trials of innovative financing arrangements; a program of comprehensive pharmaceutical management; an initiative to increase levels of quality of care; and an initiative to improve human resource management.

## Providing Leadership Through Research

A hallmark of USAID's HIV/AIDS program is ongoing biomedical and behavioral research to develop and evaluate new tools for preventing HIV transmission and mitigating the effects of AIDS. Results of this research are used to improve service delivery for those living with HIV/AIDS and to design effective interventions for prevention. USAID currently supports applied research in 21 countries, including research to develop and improve approaches to:

- ⦿ Reach youth with effective HIV prevention messages;
- ⦿ Integrate HIV testing services into existing health care settings;
- ⦿ Improve programs to prevent mother-to-child transmission of HIV;
- ⦿ Develop a safe and effective HIV vaccine and vaginal microbicides;
- ⦿ Assist children affected by HIV/AIDS; and
- ⦿ Reduce the stigma of HIV/AIDS so that affected persons can freely access available services.

Specific examples of USAID-supported research initiatives include the following:

### *Horizons: Why Does a Successful Intervention Work?*

Replicating or scaling up successful programs, particularly in a context of limited resources,

requires determining accurately what makes them successful in the first place. Through the Horizons project, USAID focuses research on how and why HIV/AIDS programs and policies work (or perhaps do not work, since much can be learned from less-than-successful efforts as well). By collaborating with government ministries, local and international nongovernmental organizations, people living with HIV/AIDS, research organizations, and multilateral and bilateral donors, USAID is able to conduct research that improves the quality and effectiveness of programs.

One recent Horizons study on HIV and partner violence in Tanzania found that HIV-positive women were almost three times more likely than HIV-negative women to have experienced an episode of violence by a current partner, though only a few HIV-positive respondents reported violence or abandonment as a result of serostatus disclosure to their partner. The study recommended that voluntary counseling and testing programs train counselors to ask about partner violence, encourage client serostatus disclosure only after a safe "disclosure plan" is agreed upon, and refer women to community-based programs that support women living in violent situations.

### *Lesedi: "We Have Seen the Light"*

A USAID-supported intervention directed at 407 high-risk women living in a South African



**Horizons currently implements more than 60 operations research activities focused on the following 10 topic areas:**

1. Prevention, diagnosis, and management of sexually transmitted infections;
2. Care and support services for persons infected with or affected by HIV/AIDS;
3. Stigmatization and discrimination against persons living with HIV/AIDS;
4. Social marketing, private sector involvement, and workplace issues;
5. Community mobilization and capacity building;
6. Gender and sexuality;
7. Youth;
8. Voluntary HIV counseling and testing;
9. Effectiveness and acceptability of barrier methods; and
10. Integration of HIV/AIDS services with maternal-child health and other services.

mining town succeeded in reducing HIV prevalence not only among the women, but in the community as a whole. The intervention, implemented by Family Health International/IMPACT, consisted of physical examinations, treatment for sexually transmitted infections, prevention education, and distribution of condoms. In addition, peer educators were trained to provide participants with information about sexual risk reduction, condom use, and the

advantages of using the available clinical services. The result was that condom use increased significantly, and sexually transmitted infections declined among the women as well as the miners living in the intervention area.

The project, called *Lesedi* (meaning “We have seen the light”), has evolved from a small pilot project in 1996–1997 to a self-sustaining intervention that is being replicated in other mining communities as well as in other areas with similar transmission dynamics. It is an excellent example of how USAID takes the results of a program, analyzes the elements of success, and replicates it in other areas.

***National Health Accounts: Information About HIV/AIDS Health Spending***

As HIV/AIDS threatens to undermine development in many countries, policymakers need information about who pays for health care and how much it costs in order to determine how best to expand coverage, access, and quality of HIV services while simultaneously meeting other urgent health needs. National health accounts provide a way of analyzing where health care system resources come from and how they are used. Through the Partners for Health Reform project, USAID has launched an initiative to use national health accounts to generate information about HIV/AIDS-specific expenditures in East and Southern Africa.

In Rwanda, the national health account framework was adapted to generate information about disease-specific expenditures. Analysis shows that approximately half of Rwanda’s annual per-capita health expenditure of \$12.70 comes from donors, 40 percent from private sources, and the remaining 10 percent from the Rwandan government. Roughly 10 percent of total health expenditures is spent on HIV prevention and treatment for those who were HIV-positive. Of this, household out-of-pocket expenditures make up 93 percent. These figures highlight the severe financial impact that HIV has on households with infected members, with treatment costs borne almost entirely by patients and their families—most of them already very poor.

This study is valuable both for the specific information it generated about HIV/AIDS spending in Rwanda, and for the lessons it teaches about collecting and using actual health care cost data in designing and implementing policy. This method is particularly useful because it captures both public and private expenditures.

***Monitoring the AIDS Pandemic: The MAP Network***

Created in 1996, the Monitoring the AIDS Pandemic (MAP) network brings together more than 100 epidemiologists, modelers, economists, and social, behavioral, public health, and international development specialists from 40 countries to assess the status and trends of

the global HIV/AIDS pandemic. The network provides objective, high-quality, and timely analysis of the most current available data on HIV/AIDS, which are used to expand national capacities to respond to the pandemic.

A recent MAP report, *HIV/AIDS in the Americas*, identified gaps in HIV/AIDS surveillance across Latin America and the Caribbean, called on countries to develop standardized surveillance indicators and specify AIDS case definitions, and encouraged stronger intercountry and intraregional networks to improve data collection and analysis.

### *Changing Population Structures: From Pyramid to Chimney*

Through USAID support, the International Programs Center of the U.S. Bureau of the Census collects and analyzes data that can shed light on shifting HIV/AIDS patterns and trends. In 2000, the Bureau released findings showing that, in countries with a very high prevalence, the population structure itself is changing in ways that could contribute to further increases in HIV, and population growth may soon turn negative.

In countries with high prevalence—for example, Botswana (36 percent), Zimbabwe (25 percent), and South Africa (20 percent)—AIDS mortality is reshaping population structures. Countries experiencing population growth generally have

population structures shaped like pyramids, in which young people—the largest segment of the population—form the broad base of the pyramid, and older people, affected by disease and death, form the narrow peak.

In countries with high AIDS mortality, women of childbearing age have fewer children because they die before their childbearing years are over, and up to one-third of children die from the disease. The combined effect of fewer births, fewer surviving children, and so many adult deaths is that only those who escape HIV infection will survive to old age. By 2020, in South Africa, for example, the number of adults in their 60s and 70s will be on par with those in their 40s and 50s (with those who are now in their 20s and 30s already having died in large numbers). The figure on p. 37 shows the dramatic difference in South Africa's population structure with and without AIDS.

One result will be dramatic shifts in dependency ratios. A small number of young adults will be caring for society's dependents—the young and the old. If these young adults are themselves sick, they will need to receive care from their children or elderly parents rather than providing it. Other impacts, not yet fully realized, could be equally profound.

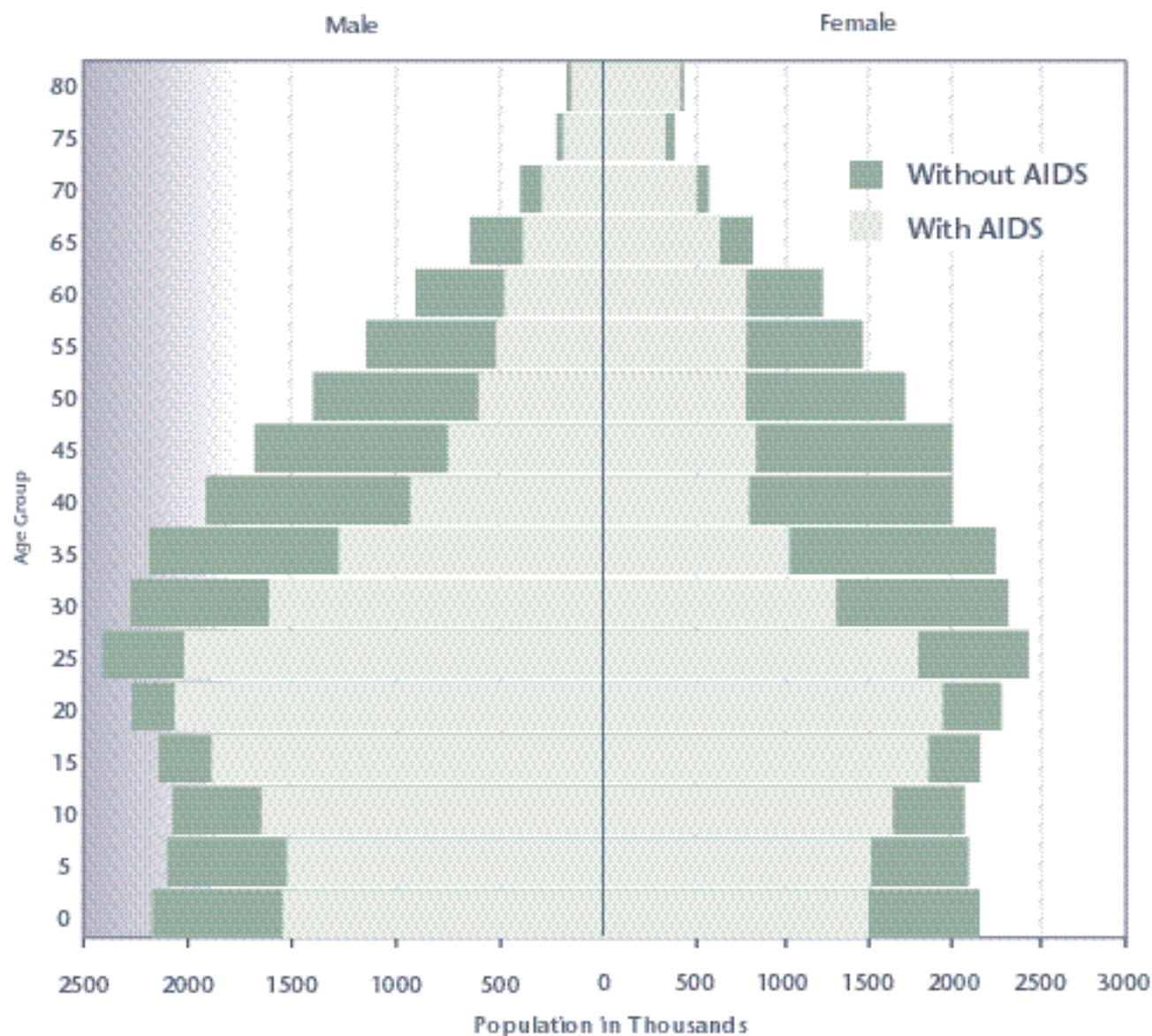
### *The Female Condom: A Viable Choice for HIV Protection*

First introduced in 1992, the female condom gives women an

effective, self-initiated method of preventing sexually transmitted infections—including HIV—and pregnancy. USAID has provided leadership and funding to evaluate and improve the female condom by researching the condom's cost-effectiveness, public health and social effects, patterns of use and acceptability, and efficacy in HIV and pregnancy prevention. The research revealed high levels of acceptability (50 to 70 percent) among both men and women who use it for both HIV and pregnancy protection, with men purchasing it almost as frequently as women. Research also showed that the female condom can be cost-saving to HIV prevention programs—despite its significantly higher unit cost when compared with the male condom—when introduced in high-risk populations and in populations that do not use male condoms consistently. Importantly, some data indicate that the number of protected sex acts increases when both male and female condoms are made available.

USAID has worked through public and private partnerships to market, distribute, and study the use of the female condom. A study in Zimbabwe, for example, found, among other things, that users of the female condom tend to be from higher socioeconomic groups. Novelty and pregnancy prevention were reported as primary reasons for initial use of the female condom, and two-thirds

## Population of South Africa, With and Without AIDS, 2020



Source: U.S. Bureau of the Census, World Population Profile 2000

of women using the female condom said they planned to use it again. Such research helps to refine marketing approaches for the female condom, which, in turn, can increase use and acceptability. USAID continues to support research in developing countries to improve the use, acceptability, and efficacy of the female condom.

### Working in Partnership

Collaboration with partners—including donors, national governments, and a range of host country and U.S.-based institutions and community organizations—is a distinctive feature of USAID's HIV/AIDS program. These established relationships provide the foundation for USAID's expanded response to

HIV/AIDS and bolster efforts to build sustainable systems, use participatory approaches, and incorporate lessons learned.

To meet the goals outlined in its "expanded response," USAID will mobilize its vast network of partners to achieve maximum impact, avoid duplication, ensure broad coverage, monitor





and evaluate the cumulative effect of interventions, and identify and share innovations and accomplishments.

Leadership at the national, community, and individual levels is an essential element in starting and sustaining HIV/AIDS interventions. USAID relies on its developing world partners to take the lead in mobilizing political will, identifying vulnerable groups, and promoting behavior change, among other roles, to maximize the benefits of USAID support. In Senegal, Thailand, and Uganda, for example, early and decisive leadership was critical in arresting the spread of HIV/AIDS. USAID will contin-

ue to work with national governments to help them develop policies, laws, and programs that will reduce HIV transmission and provide services and care for those already affected.

#### *Nongovernmental, Community-Based, and Faith-Based Organizations*

Nongovernmental organizations are among the most effective vehicles for reaching individuals at high risk of HIV infection, as well as those most in need of care and support. USAID missions in more than 50 countries work directly with these groups, at both the local and international levels, to provide technical assistance, training, technol-

ogy exchange, and institutional support. In fact, more than 70 percent of USAID's HIV/AIDS support over the years has been allocated to nearly 1,000 nongovernmental organizations operating worldwide.

In many developing countries, community- and faith-based organizations administer a significant portion of health and social services, making them key partners in responding to the AIDS crisis. USAID has long supported faith-based organizations in implementing agriculture, education, disaster relief, and microenterprise initiatives, and more recently, programs supporting those affected by HIV/AIDS.



Several USAID-supported activities are under way to promote and facilitate faith-based groups in their work to scale up HIV/AIDS programs. A December 2000 workshop, held in conjunction with the White House, brought together developing country faith groups to explore how they can more effectively address HIV/AIDS and how USAID can best support them. Based on the results of the workshop and additional input, USAID is finalizing plans for the Communities Organized in Response to the HIV/AIDS Epidemic (CORE) Values project, which will emphasize building the capacity of faith-based organizations to meet care and support needs (particularly for orphans and other vulnerable children); reducing stigma and discrimination; and mobilizing the many human and material resources such organizations represent.

Examples of USAID collaboration with nongovernmental, community- and faith-based groups include the following:

- ⊙ In Namibia, Catholic AIDS Action is working in three regions to provide HIV/AIDS prevention and education for parents, teachers, and pupils, along with a range of services, including covering school expenses and other costs for a group of orphans and children affected by HIV/AIDS.
- ⊙ In Malawi, USAID funds the Community-Based Options for Protection and

Empowerment project, which helps communities reach out and care for their vulnerable neighbors, including orphans and families affected by HIV/AIDS. The project provides technical assistance to local organizations and churches, and, since 1995, has provided care and support to 12,583 orphans and vulnerable children in four districts in Malawi. Both the Episcopal Conference and Save the Children have collaborated with the project on HIV/AIDS prevention and mitigation initiatives.

- ⊙ The Central America HIV/AIDS Prevention project supports nongovernmental organizations in seven countries—Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama—by promoting strategic alliances among networks, improved data collection, and electronic and personal information sharing.

### *Bilateral and Multilateral Donors*

Collaboration with other bilateral and multilateral donors is essential to ensuring that all efforts complement and reinforce each other, without duplication. USAID has been an active partner with the United Nations in fighting HIV/AIDS, first through the World Health Organization and then through UNAIDS, to which USAID is the single largest donor. USAID

also coordinates with other bilateral donors, at both the policy and the field levels, to reinforce activities and share information. Partnerships with the United Kingdom's Department for International Development, the European Union, and Japan have been particularly effective. Most critically, USAID missions work with national ministries of health and national AIDS programs to respond to specific needs at the national level.

As the world's lead donor in HIV/AIDS, USAID will continue to promote ongoing collaboration in the fight against the pandemic, particularly on the part of multilateral organizations such as UNAIDS, the World Health Organization, and the World Bank. Through convening international stakeholders, setting standards for HIV/AIDS programming, and mobilizing donors, these organizations have played a critical role in accelerating the global response.

### *U.S.-Based Partners*

USAID partners effectively with U.S. government agencies, corporations, and private foundations to develop, implement, and scale up its HIV/AIDS programs worldwide. Collaborative efforts with the Centers for Disease Control and Prevention aim to strengthen the capacity of countries to collect and use surveillance data and manage national HIV/AIDS programs, while programs developed with the Department of Defense focus on educating African military

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## Monitoring and Evaluation Handbook: A Collaborative Effort

The *USAID Handbook of Indicators for HIV/AIDS/STI Programs*, first published in March 2000, was designed to meet the program monitoring and evaluation needs of USAID programs. Development of the handbook began in 1998 and initially involved only the key partners involved in the USAID program. Soon, however, this effort included a number of multilateral and nongovernmental organizations, in addition to the national programs of Brazil, India, Jamaica, Kenya, Mexico, South Africa, Thailand, Uganda, and Zambia. This larger group set as an objective the development of a standardized set of indicators and instruments to monitor and evaluate national HIV/AIDS programs.

The broader international consultative process resulted in the publication of *National AIDS Programmes: A Guide to Monitoring and Evaluation* in June 2000. As with the *USAID Handbook of Indicators*, the purpose of the *Guide* is to make available a set of standardized indicators and data collection instruments that will enable program managers to consistently collect and analyze data that will be most useful for program monitoring and evaluation, thus ensuring more effective use of scarce resources. This standard set of indicators and instruments will also enable program managers to track results over time by target populations, intervention, region, and country—a process made difficult by the application of different sets of indicators and instruments in previous years.

The two handbooks are similar; many of the indicators are common to both, which will allow for comparability of program results. The *USAID Handbook of Indicators* also includes additional indicators for the measurement of private sector responses. Indicators for measuring strengthened data collection for program monitoring and evaluation, and effective program implementation are under development. USAID missions and regional bureaus are beginning to use these standardized indicators to report on program results and to set objectives and targets for newly designed programs. The adoption of these standards across USAID will greatly improve its ability to report globally on achievements.

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troops about HIV prevention. Activities to improve the workplace environment for persons living with HIV/AIDS and educate workers about prevention methods are being carried out in partnership with the Department of Labor, and a cooperative agreement with the U.S. Peace Corps enables volunteers to conduct training in HIV/AIDS prevention and promote community outreach efforts.

In one example of collaboration with the private sector, the Population Council's Horizons Program secured a donation of the antibiotic azithromycin from the pharmaceutical company

Pfizer, Inc. After reviewing research protocols for sexually transmitted infection and HIV intervention studies in South Africa, Zimbabwe and Zambia, Pfizer agreed to donate the drugs for use in two USAID-supported studies to evaluate the effect of periodic treatment of sexually transmitted infections as a component of a comprehensive HIV/sexually transmitted infection prevention program.

USAID has also had success in leveraging foundation support for HIV/AIDS initiatives in the developing world. Since 1999, the Bill and Melinda Gates Foundation has awarded grants to three USAID cooperating

agencies—the Peace Corps, The Population Council, and Population Services International—to support HIV/AIDS research and education worldwide. Other examples include a \$2.75 million United Nations Foundation grant to UNAIDS to develop youth-friendly health services and voluntary HIV/AIDS counseling and testing programs in Mozambique; and a \$150,000 Ford Foundation grant to the Global Health Council to link organizations working on HIV/AIDS in the United States with those based in other countries.

## Creating an Enabling Environment

For programs to be effective, the larger context in which they take place must be supportive. To that end, USAID looks for ways to mitigate broader issues surrounding the pandemic, such as stigma and discrimination, food insecurity, lack of infrastructure, and gender inequality, which increase communities' vulnerability to HIV/AIDS and facilitate its spread. Advocacy for legislative and policy changes to assist and protect persons living with HIV/AIDS is another key area of intervention.

### *Gender Issues: The Role of Women in Preventing HIV/AIDS*

Until the mid-1990s, women's part in the AIDS crisis was given relatively little recognition. Women now comprise nearly half of all infected adults (and in Africa, more than half); among younger women, the proportion is particularly high. Women also bear much of the burden of caring for HIV-infected family members and risk passing HIV on to their infants.

Recognizing the particular difficulties women and girls face, USAID's HIV/AIDS services strive to inform and support them. USAID programs:

- ⊙ Work in or through services women use (i.e., maternal, child, and other health services);
- ⊙ Help women develop realistic, personalized action plans

to reduce their risk of HIV infection and to access the services they need;

- ⊙ Acknowledge and, where possible, address the economic and political conditions that put women at a disadvantage;
- ⊙ Develop microfinance initiatives to mitigate the effects of HIV/AIDS on families;
- ⊙ Educate widows about inheritance rights;
- ⊙ Pay special attention to the needs and participation of girls; and
- ⊙ Engage men, as well as women, in supporting the health and welfare of women and girls.

One USAID-supported study in Senegal reported great success in increasing and destigmatizing condom distribution among women for use in preventing HIV/AIDS. Researchers recruited members of two traditional women's associations to distribute condoms and promote them as part of community ceremonies and small group discussions about prevention of HIV/AIDS and other sexually transmitted infections. In a culture where women are often reluctant to ask medical personnel for condoms because they fear being viewed as sex workers, this peer-to-peer approach provided an acceptable means of obtaining condoms. Study findings showed a significant increase in female-reported condom use in neighborhoods

where the women's associations were active.

### *Human Rights*

Because of the stigma and discrimination that surround HIV/AIDS, protecting the human rights of persons living with HIV/AIDS and their caregivers is a constant concern. Among the issues that need attention are discrimination in the workplace, the legal rights of persons living with HIV/AIDS, attitudes of the media and of medical personnel, and the human and legal rights of caregivers.

In an effort to learn more about how to incorporate such issues into HIV/AIDS prevention and care programs, a USAID project in Zambia set out to educate the public about HIV-related discrimination. Implemented over three months in 2000 by the USAID-funded Policy Project and three Zambian nongovernmental organizations, the human rights and HIV/AIDS project included three components:

- ⊙ An assessment of the legal rights of Zambian persons living with HIV/AIDS;
- ⊙ A mass media/advertising campaign to convey the message that persons living with HIV/AIDS cannot be fired, denied employment, or discriminated against because of their HIV status; and
- ⊙ Training of counselors to provide legal advice and referrals for persons living with HIV/AIDS who

responded to the media campaign.

As a result of the project, about 70 persons living with HIV/AIDS came forward to seek advice and referrals. The initiative will be expanded with support from USAID and other donors to include additional countries and additional issues.

### *Involving People Living with HIV/AIDS in Community and Country Programs*

Since 1994, when USAID played a major role in supporting the Greater Involvement of People Living with AIDS Initiative, recognition has been growing that persons living with HIV/AIDS have an important role to play in the design and implementation of HIV/AIDS prevention and care programs. Creating an environment in which persons living with HIV/AIDS are comfortable about coming forward as educators and community mobilizers has become an important focus for USAID. This requires overcoming stigma and discrimination as well as learning more about how best to involve persons living with HIV/AIDS in community organizations.

In Burkina Faso, the USAID-funded Horizons project examined how organizations and programs involve persons living with HIV/AIDS and what kind of positive and negative effects such involvement has on the organization, the community it serves, and the individual. The study concluded that, when

done well, involvement of persons living with HIV/AIDS makes programs more effective, appropriate, and meaningful. Prevention messages delivered by persons living with the infection are a powerful voice on behalf of behavior change, even as they help to humanize the HIV-infected messenger (and thus remove fear and stigma). And care and support services provided by a person living with HIV/AIDS are particularly comforting to the recipient, who may have no one else to lean on. Involvement in HIV/AIDS programs also benefits persons living with HIV/AIDS by reducing their isolation and empowering them to make a difference. Organizations that involve persons living with HIV/AIDS in their education and care programs reap many benefits, including better information about what persons living with HIV/AIDS need and increased credibility with the community they are trying to serve.

The Burkina Faso study, which was the first of several similar country studies, had an immediate effect on the participating community-based organizations, which addressed issues coming out of the study, particularly sharing decision-making with persons living with HIV/AIDS. The research also affected policy made on the national level (Burkina Faso is developing a countrywide strategy on community-based care and support) and on the international level (study results are informing the design and implementation of

similar studies in other regions by Horizons and others).

### *Policy Dialogue and Advocacy*

A supportive policy environment, including strong political commitment from leaders and program managers, is essential for creating a broad-based, sustained approach to the HIV/AIDS pandemic. It is essential to ensuring that human rights are respected, that stigma and discrimination are eliminated, that overall national guidelines and plans are developed and pursued, and that financial and human resources are mobilized to build capacity in government and elsewhere to sustain a response. The USAID-funded Policy Project develops activities and programs to strengthen the capacities of public and private sector institutions as well as nongovernmental organizations. It has conducted HIV/AIDS policy activities in 12 countries.

An important part of good policy development involves using effective advocates to promote effective policies. For this reason, the Policy Project trains stakeholders who may not otherwise be included in the policy process—including formal groups from civil society (including nongovernmental organizations, women's groups, universities, and professional associations), research institutions, pharmacies and other health service providers, and individuals—to develop and implement advocacy strategies.





Photo: Rich Marchewka

## *The Changing Global Context*

For most of the last two decades, both policymakers and health professionals have underestimated the magnitude, virulence, and impact of the HIV/AIDS pandemic, too often thinking it could be kept from their borders or contained within discrete populations whose behaviors put them at higher risk. In the last two years, however, an increasing number of political leaders and health professionals around the world have begun to recognize that the task is much bigger than they ever imagined and that slowing the pandemic will require committed national leadership and a coordinated international response across many sectors.

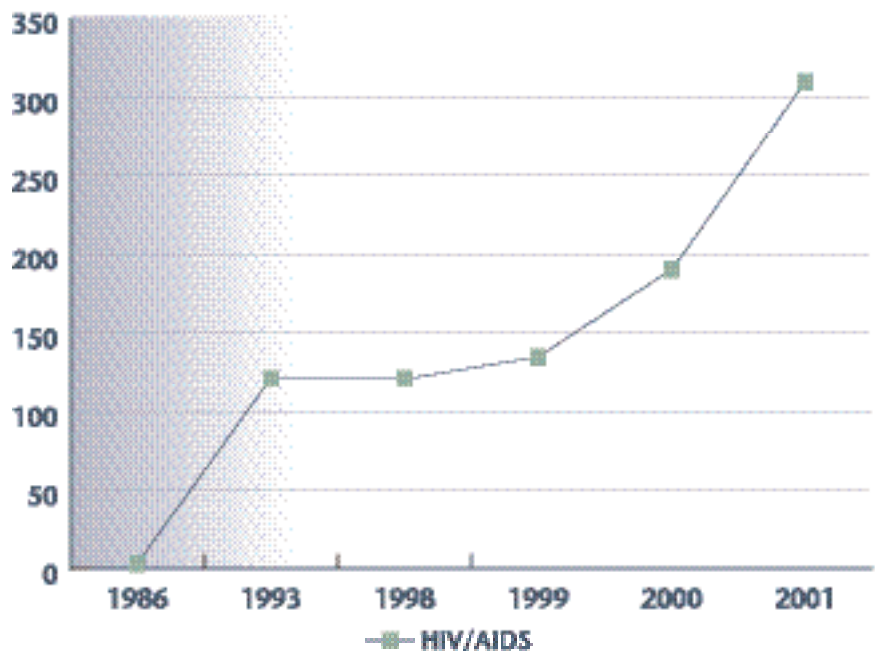
### **National Leadership Key to Success**

The degree to which a country can prevent or respond to its

own epidemic depends on factors ranging from the political will of its leaders to the amount

of human and capital resources available. The countries that have been most successful in

**USAID HIV/AIDS and Infectious Disease Funding  
FY 1986-2001 (\$ millions)**



Source: USAID

## India's Tamil Nadu—A Model for Prevention and Control

Considered one of the pandemic's next epicenters, India is struggling to confront the impact of HIV/AIDS on its population of 998 million people, 3.7 million of whom are currently infected. USAID has been at the forefront of raising HIV/AIDS awareness in India and creating effective prevention programs to contain the disease before it jumps from high-risk groups to the general population—a transition that could happen swiftly in a densely populated country.

One of the most successful initiatives in slowing the spread of HIV/AIDS among groups at high risk of infection is being carried out in the southeastern state of Tamil Nadu, where HIV infection rates among pregnant women tripled between 1995 and 1997. The state's AIDS Prevention and Control Project—launched in 1995 as the first major bilateral HIV/AIDS prevention program in India—joins more than 40 community-based organizations in training peer educators and counselors to promote a reduction in the number of sex partners, increased condom use, and diagnosis and treatment of sexually transmitted infections among high-risk groups such as sex workers, truckers, and slum dwellers.

The project's peer-to-peer approach has paid off. A survey conducted four years into the project found:

- ⊙ The proportion of truckers and their helpers engaging with nonregular sex partners dropped from 48 percent to 21 percent from 1996 to 1999;
- ⊙ Sixty-seven percent of truckers and their helpers reported condom use in 1999, up from 44 percent in 1996;
- ⊙ Eighty-eight percent of sex workers reported condom use with clients in 1999, compared with 56 percent in 1998;
- ⊙ Ninety percent of truckers said they sought treatment from a health care provider for symptoms of sexually transmitted infections in 1999—a 26 percent increase from 1998.

An independent evaluation of the project concluded that these behavior changes could be directly attributed to the project and an aggressive prevention initiative implemented by the Tamil Nadu AIDS Control Society. Annual condom sales in the state more than doubled between 1995 and 1999, jumping from 12.6 million units to 27.9 million units. Evaluators recommended that the 10-year project be scaled up to reach additional regions in Tamil Nadu and that additional population groups and community-based care services be added.

stemming the spread of HIV had bold, decisive leadership at an early stage. The best example is in Uganda, where President Yoweri Museveni recognized the dangers of AIDS early on and intervened with a mix of voluntary HIV testing, condom distribution, education, and counseling and support services—an approach that has yielded impressive results. HIV infection fell by half

between 1992 and 1999, and Uganda is providing a range of services to improve the lives of the more than 800,000 Ugandans living with HIV/AIDS and their families.

A number of countries have managed to contain the incidence of HIV infection by focusing prevention efforts on their highest risk populations. In the Philippines, for example,

registered sex workers reduce their risk by using condoms regularly. They are also screened twice a month for sexually transmitted infections and treated if any are discovered. Senegal has kept its rate of infection under 2 percent through a multipronged prevention effort, aided by reinforcing conservative cultural norms regarding sex. Other places such as Thailand and the Indian state of Tamil Nadu have

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## The Role of UNAIDS

The United States is one of 22 United Nations member states on the board of UNAIDS, along with five nongovernmental organizations and seven United Nations cosponsors. The United States has been the largest donor to UNAIDS, accounting for roughly one-quarter of its annual budget.

Results of an evaluation of UNAIDS' first five years are due in May 2002. UNAIDS' contributions to combating the pandemic include:

- ⊙ Elevating AIDS to the top of the world's political agenda;
  - ⊙ Shaping global perceptions of AIDS as a multisectoral, health, and development crisis that must be addressed through mutually reinforcing strategies of care and prevention;
  - ⊙ Fostering a public-private sector dialogue to expand access to antiretroviral drugs;
  - ⊙ Improving coordination of the U.N. system's response to HIV/AIDS;
  - ⊙ Increasing national and international resources; and
  - ⊙ Fostering an appreciation of the huge gap between resources and need in the HIV/AIDS field.
- 

conducted high-profile campaigns to reduce rapidly rising infection rates.

## The International Response: Increasingly Urgent

In the mid-1990s, as the pandemic spread and its devastating toll became more apparent, the international community realized that concerted effort to achieve maximum impact was needed among donors. USAID collaborated with other bilateral donors, the World Health Organization, and other U.N. agencies to take the innovative step of creating UNAIDS in 1996, through which the cosponsoring organizations share information, plan and monitor coordinated action, and jointly support major HIV/AIDS activities. UNAIDS

has been an effective global voice, documenting and publicizing the full dimensions of the global HIV/AIDS crisis and focusing high-level attention on the problem.

Recognizing that efforts to address HIV/AIDS in Africa have not kept pace with the rapidly spreading epidemic, UNAIDS led the collaboration that created the International Partnership Against AIDS in Africa (IPAA) in 1999. IPAA has been instrumental in mobilizing political commitment and coordinating the efforts of African governments, UNAIDS and other donors (bilateral and multilateral), private sector participants (including multinational corporations, pharmaceutical firms, foundations, and trade unions), and the community sector (including international,

national, and community organizations; academic and research institutions; and others). It is an ambitious, multisectoral group with a simple mission: reduce the number of new HIV infections in Africa, promote care for those who suffer from the virus, and mobilize society to halt the advance of AIDS.

The pace and level of international attention accelerated throughout the year 2000. In January of that year, the U.N. Security Council met to discuss the impact of HIV/AIDS on peace and security in Africa—the first time HIV/AIDS was discussed as a global security threat at such a high level. The Security Council repeated its warning in July and called on all U.N. agencies to make reducing HIV/AIDS infection rates a priority within the context of



Photo: Project Concern International

their respective mandates. In September, the international community again stressed the need for and commitment to a coordinated attack on HIV/AIDS when more than 150 of the world's leaders met at the Millennium Summit and set targets for reducing the HIV infection rate and increasing access to prevention methods.

In June 2001, alarmed at the continued rapid spread of the pandemic and still-lagging response, the United Nations General Assembly convened a Special Session "to intensify international action and mobilize the resources needed." The Assembly adopted a Declaration of Commitment on HIV/AIDS that lays out a series of targets for international action over the next decade.





Photo: Johns Hopkins University

## *Looking Ahead*

In the 20 years since the first AIDS case was identified, 60 million people were infected with the virus. More than 22 million have already died. And the pandemic shows no signs of slowing: around the world, 10 people are infected every minute.

But the numbers, as alarming as they are, cannot fully convey the tragedy of AIDS: more than 95 percent of the people living with AIDS today live in developing countries—the vast majority in sub-Saharan Africa. This means that AIDS most often strikes those whose lives are already beset by poverty and hardship, and it hits most often in countries where governments cannot afford to provide treatment or life-prolonging medication. Death is the only and inevitable outcome.

The discovery of an AIDS vaccine is perhaps our best hope—but such an event is years, if not decades, away. Still, we know what works now. There is an international strategy, there is political commitment, and there are resources to employ both. It is now up to us, as governments, development organizations, private businesses, and indeed, as citizens, to take up this imperative, and “scale up” the war on AIDS.

Since the first years of the pandemic, when the Centers for Disease Control and Prevention published a brief report on a mysterious new disease, the United States has been a leader on AIDS and AIDS-related issues. Our commitment to preventing this disease has saved the lives of countless numbers of men, women, and children. Our

commitment to treating AIDS has helped many more lead longer lives, and made those lives more livable.

In the coming years and decades, we must continue our efforts to erase the ignorance, misinformation, and fear that surrounds AIDS. We know that in sub-Saharan Africa, a limited number of those living with AIDS have access to even basic care, so we must find more ways to help those living with HIV/AIDS. We must work to help the millions of children orphaned by this disease. And finally, we must work to combat the poverty on which AIDS preys.

This is our challenge.

The global community is rising to meet that challenge. The United Nations hosted a his-

toric meeting on HIV/AIDS, attended by leaders from around the globe. More than 180 countries pledged to increase their commitment to HIV/AIDS and to meet specific goals for fighting the pandemic over the next 10 years.

New partners are joining the fight every day. Coca-Cola will be delivering condoms across South Africa at the same time it delivers soft drinks. A consortium of foundations has pledged

5 percent of its overall funding to HIV/AIDS programs. And the newly established Global AIDS and Health Fund is receiving pledges from corporations, foundations, and countries from across the economic spectrum, from the United States to Nigeria.

In the history of civilization, few circumstances have arisen where people from all over the world came together in the pursuit of one goal. Whether it be the

struggle for freedom, for equality, or for the eradication of a disease, these moments stand out because governments, leaders, and private citizens were able, for however short a time, to put aside their differences and work together for the betterment of humankind.

As we enter the 21st century, let us pledge to make this, the global effort against AIDS, one of those moments. This too, is our challenge.



Photo: UNICEF Murray/Lee

## *HIV in the Developing World: Maps*

The seroprevalence data presented below are taken from the HIV/AIDS Surveillance Database of the International Programs Center, Population Division of the U.S. Bureau of the Census. They represent the best available data on HIV seroprevalence among selected populations in urban areas of developing countries. Seroprevalence data are not provided for rural populations because they are not available for many countries. However, it should be noted that HIV seroprevalence rates in rural areas generally are considerably lower than urban rates.

The map on pages 50-51 shows the median HIV-1 prevalence among samples of urban indi-

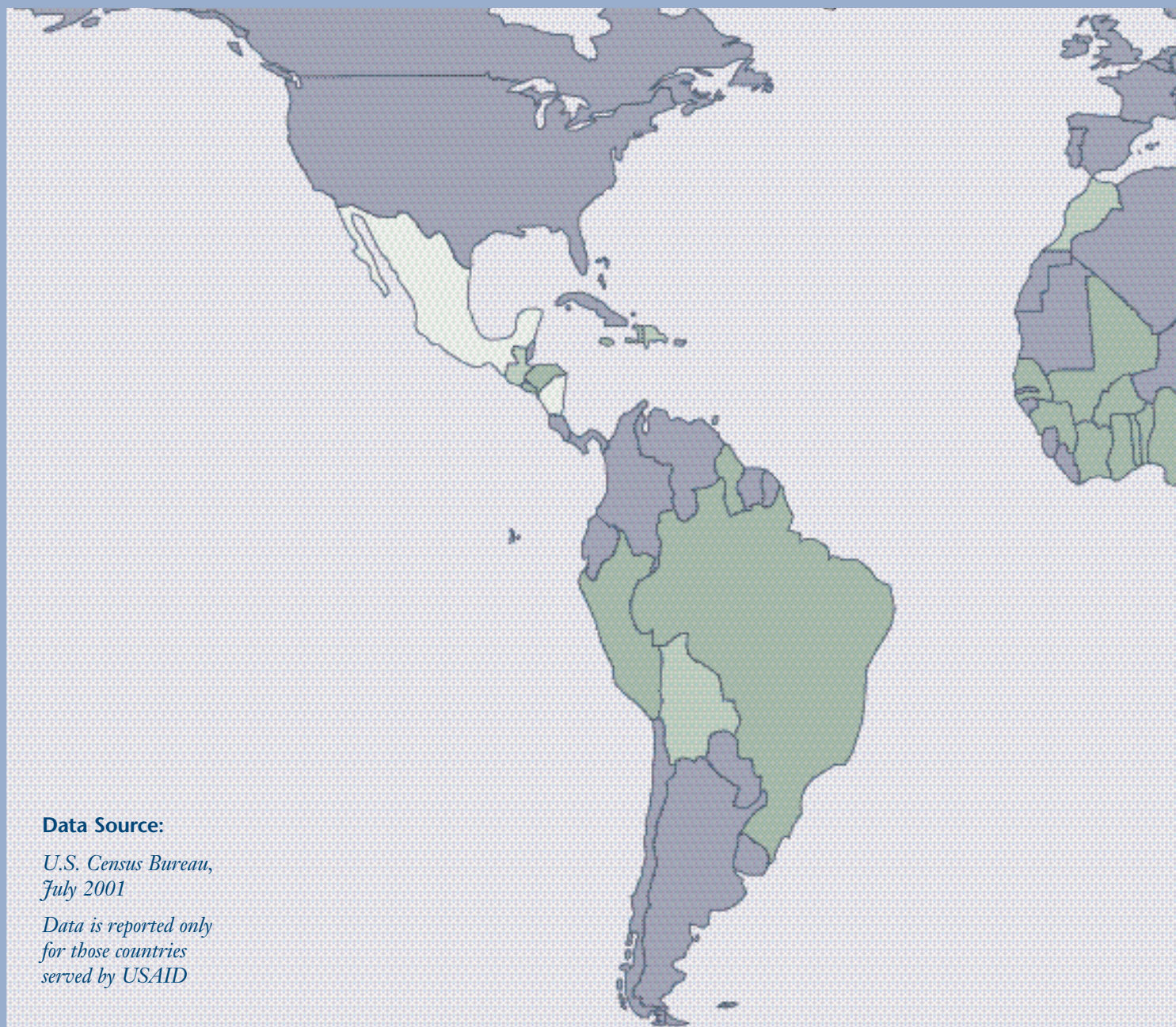
viduals at high risk, including sex workers and STD clinic patients. The map on pages 52-53 shows the median HIV-1 prevalence among samples of women attending antenatal clinics, a population considered to be representative of the general adult population.

Because surveys of HIV seroprevalence are not based on national samples, seroprevalence estimates have a bias if generalized beyond the sample population. To minimize bias and confusion in using current seroprevalence estimates, the most representative sample estimates were selected according to the following criteria:

- ⊙ Larger samples were generally favored over small samples.
- ⊙ More recent estimates were selected over older estimates.
- ⊙ Better documented data were selected over poorly documented data; data without documentation were not used.

These criteria can only minimize the biases in the data, not eliminate them. Therefore, all seroprevalence data should be used with caution.

# HIV Prevalence Rate Among Urban Populations



 **Countries with Low Seroprevalence Ranges (0%-0.9%)**

## Asia/Near East

Egypt	0
Indonesia	0.2
Philippines	0.1

## Latin America/Caribbean

Mexico	0.3
Nicaragua	0.2

 **Countries with Medium Seroprevalence Ranges (1.0%-4.9%)**

## Africa

Madagascar	1.0
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## Asia and Near East

Laos	1.2
Morocco	1.3

## Latin America/Caribbean

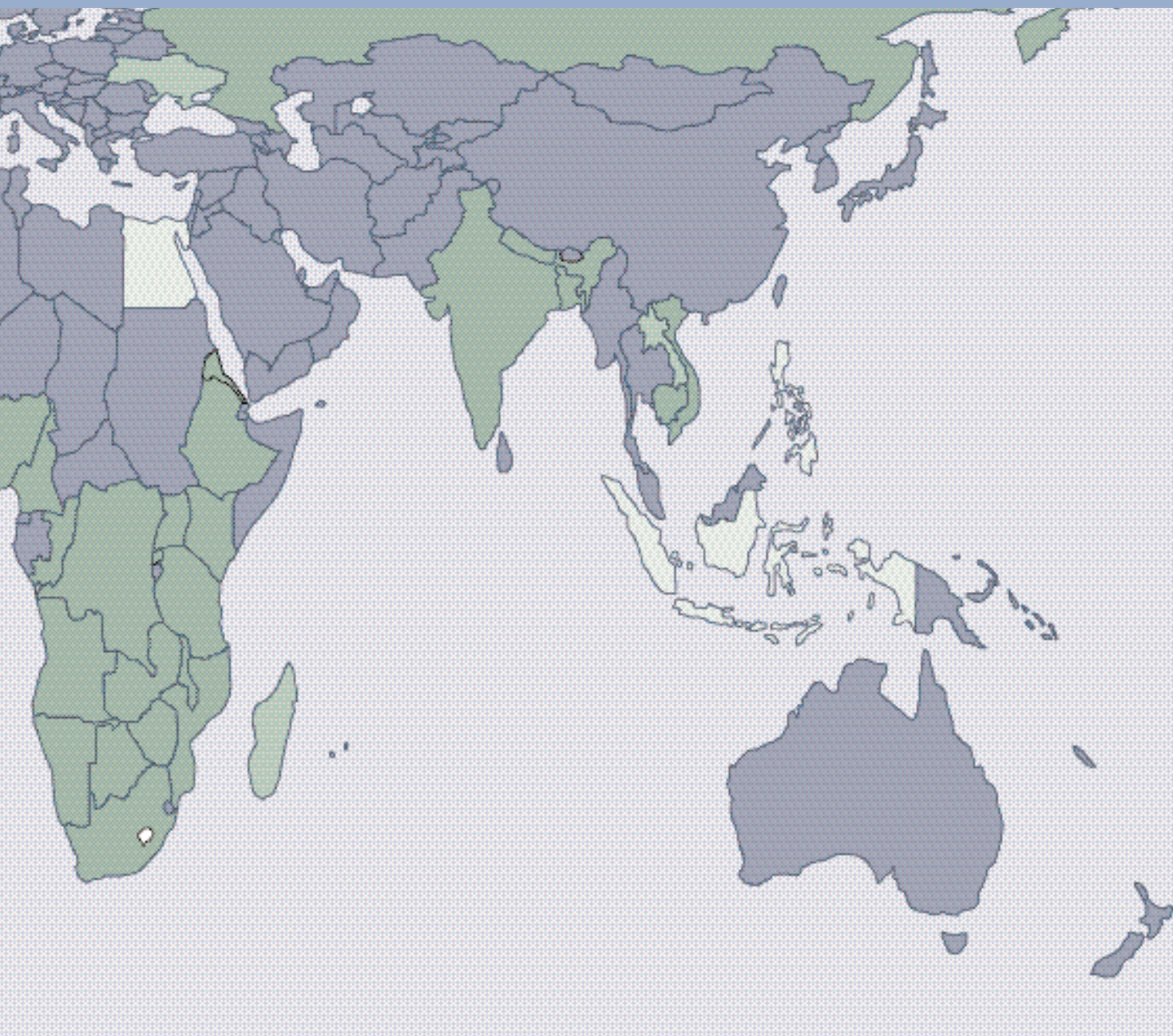
Bolivia	2.0
Dominican Republic	4.6
Guatemala	4.7

## Europe/Eurasia

Ukraine	3.1
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# at High Risk



## Countries with High Seroprevalence Ranges (5.0%+)

### Africa

Angola	19.4
Benin	41.0
Botswana	46.0
Burkina Faso	28.6
Cameroon	33.3
Congo	49.2
Côte D'Ivoire	36.0
Democratic Republic of Congo	29.0
Eritrea	35.0
Ethiopia	73.7
Ghana	
Guinea	
Kenya	
Malawi	
Mali	
Mozambique	
Namibia	
Nigeria	
Rwanda	
Senegal	
South Africa	
Tanzania	

72.6	Togo
36.6	Uganda
74.4	Zambia
70.4	Zimbabwe
21.0	

### Asia/Near East

44.6	Bangladesh
30.5	Cambodia
42.1	India
6.1	Nepal
69.0	Vietnam
24.4	

### 78.9 Latin America/Caribbean

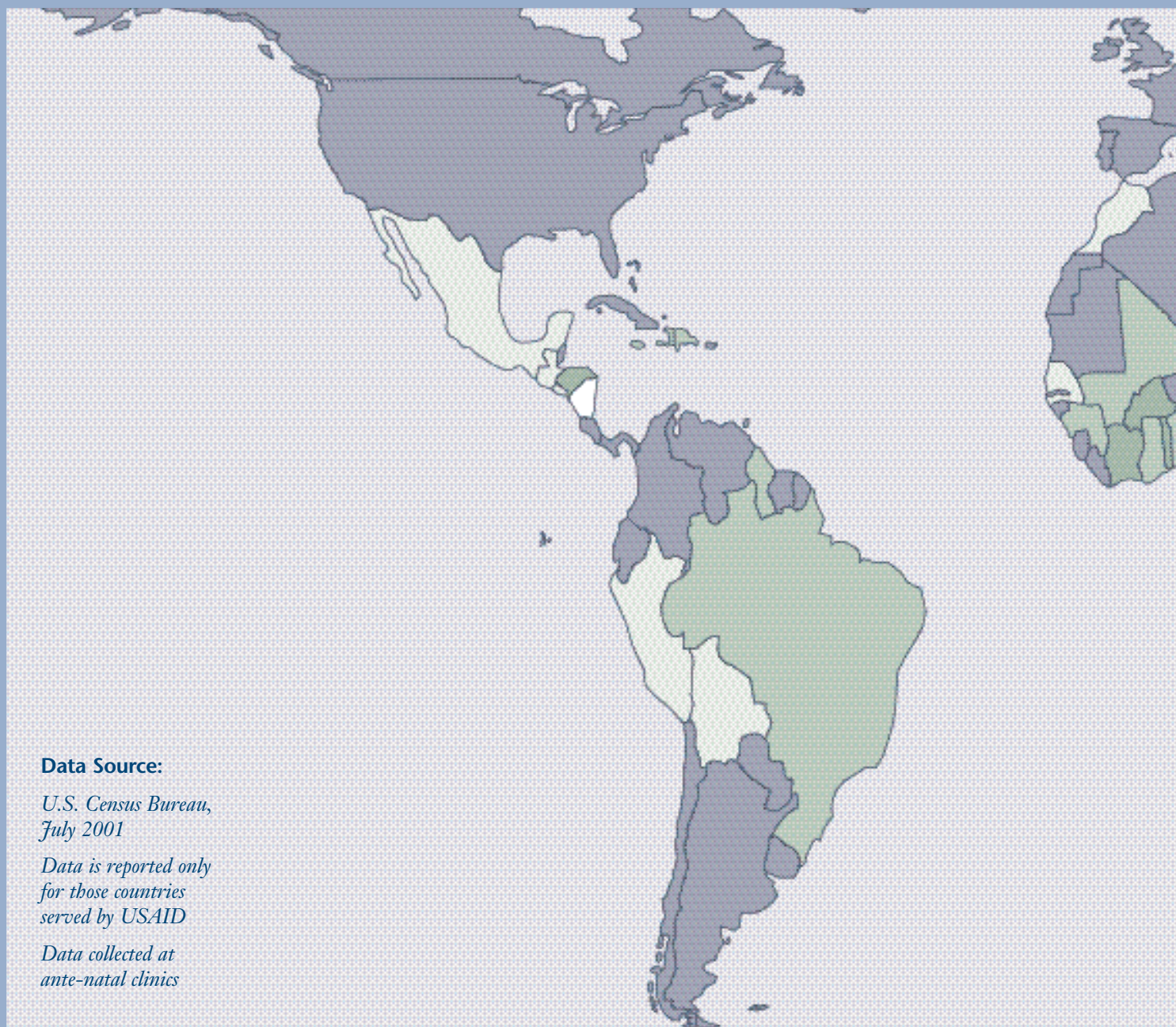
29.4	Brazil	42.0
68.7	El Salvador	5.3
86.0	Guyana	43.6
	Haiti	41.9
	Honduras	13.0
	Jamaica	6.4
	Peru	12.2

### Europe/Eurasia

26.9	Russia	15.3
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# HIV Prevalence Rate Among Women of Child-



## Countries with Low Seroprevalence Ranges (0%-0.9%)

### Africa

Madagascar	0.1
Senegal	0.4

### Asia/Near East

Egypt	0
Indonesia	0
Laos	0.4

### Morocco

Nepal	1
Vietnam	0.2

### Latin America/Caribbean

Bolivia	0.5
El Salvador	0.3
Guatemala	0.8

### Mexico

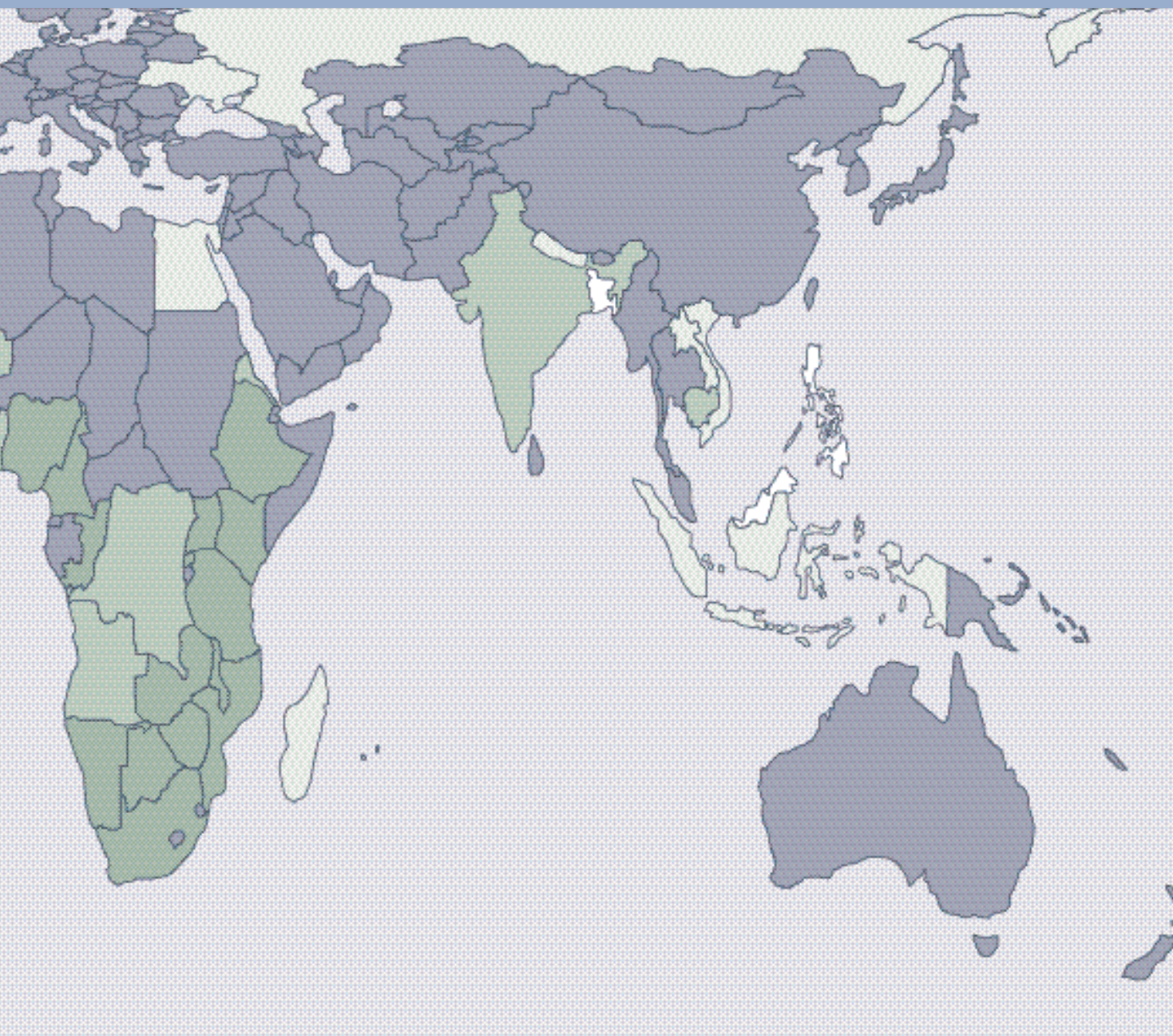
Peru	0.1
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### Europe/Eurasia

Russia	0
Ukraine	0.4



# Bearing Age



## Countries with Medium Seroprevalence Ranges (1.0%-4.9%)

### Africa

Angola	3.4
Benin	2.3
Democratic Republic of Congo	4.1
Eritrea	4.0
Ghana	2.7
Guinea	1.5
Mali	2.5

### Asia/Near East

Cambodia	4.9
India	2.6

### Latin America/Caribbean

Brazil	1.6
Dominican Republic	1.2
Guyana	3.8
Haiti	3.8
Jamaica	1.0

## Countries with High Seroprevalence Ranges (5.0%+)

### Africa

Botswana	43.9
Burkina Faso	5.7
Cameroon	5.6
Congo	5.4
Côte D'Ivoire	9.0
Ethiopia	14.3
Kenya	16.7
Malawi	28.5
Mozambique	9.9
Namibia	22.7

### Nigeria

Rwanda	13.3
South Africa	36.2
Tanzania	15.8
Togo	6.8
Uganda	11.4
Zambia	27.1
Zimbabwe	28.0

### Latin America/Caribbean

Honduras	5.0
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## Africa

The extent and size of the HIV/AIDS pandemic in sub-Saharan Africa means it is not only quantitatively different from the epidemics in other regions of the world, but qualitatively different as well. Since the beginning of the pandemic, 84 percent of all AIDS deaths worldwide have occurred in sub-Saharan Africa. An estimated 71 percent of the global total of adults and children living with the disease live in this region. Approximately 95 percent of all AIDS orphans in the world live in sub-Saharan Africa, which is the only continent where AIDS is now the leading cause of death among adults and children. In all heavily infected countries in the region, mortality is still increasing and will continue to do so through 2020.

Sub-Saharan Africa will remain the epicenter of the pandemic for many years to come. In 16 sub-Saharan countries, at least one in 10 adults is now infected with HIV, and both adults and children

are acquiring the virus at a higher rate than ever before. The region reported approximately 3.8 million new infections in 2000 alone, the vast majority of which were due to sexual transmission. Some 8.6 percent of all adults in that region are HIV-positive compared with only 0.6 percent of Americans. This share of the HIV/AIDS burden is extremely disproportionate because the region contains only 11 percent of the global population.

However, interventions are working. At the end of 2000, for the first time since the HIV/AIDS pandemic began, UNAIDS reported a decline in new infections in sub-Saharan Africa. The epidemic is reaching saturation point in sexually active populations—everyone who can get infected has already been infected—although the opportunity for second-generation epidemics cannot be discounted, if prevention programs are not successful with a new generation of young people who are becoming sexually active.



## Differences Within the Region

Southern Africa continues to be the most seriously affected area. Botswana has been hardest hit, with nearly 36 percent of adults infected. In South Africa, close to 20 percent are infected—up from 12.9 percent two years ago—making it the country with the greatest number of HIV-infected persons at 4.2 million. According to UNAIDS, seven countries now have an estimated adult HIV prevalence of 20 percent or greater: Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe. Malawi and Mozambique are both approaching that level.

Botswana, South Africa, and Zimbabwe will experience negative population growth by 2003, according to the U.S. Census Bureau projections, and growth will continue to decline in these countries through 2010. Population growth rates in Lesotho, Malawi, Mozambique, Namibia, and Swaziland will approach zero by 2010. This is the first time the U.S. Census Bureau is projecting negative population growth due to AIDS for any country.

In many countries with severe HIV/AIDS epidemics, population pyramids that have never been seen before will result from negative and near-zero population growth rates. This will be especially apparent in Botswana, South Africa, and Zimbabwe. Life expectancy in Botswana is 39 (compared with 71 before AIDS) and in Zimbabwe, 38 (compared with 70 before AIDS). Four other countries in sub-Saharan Africa have life expectancies below 40 (Malawi, Mozambique, Rwanda, and Zambia). By 2010, the Census Bureau expects that many countries in Southern Africa will have life expectancies at or below 30: Botswana, 29; Namibia, 33; Swaziland, 30; and Zimbabwe, 33; a level not seen since the beginning of the 20th century.

In the space of four decades, life expectancy at birth—the number of years a person could expect to live from the time he or she was born—rose by 15 years, from 44 in the early 1950s to 59 in the early 1990s in Southern Africa. Now, because of AIDS, life expectancy will drop to 45 in these

countries between 2005 and 2010. This will bring sub-Saharan African life expectancies back to their levels of 50 years prior. By comparison, in South and Southeast Asia, where many countries have poverty levels similar to those found in Africa, life expectancy will have increased to 67 by 2010 from 40 in the 1950s. These differences reflect the vast differences in HIV/AIDS epidemics in the two regions and their anticipated impact.

The U.S. Census Bureau has revised its estimates of crude death rates upward 50 to 500 percent in Eastern and Southern Africa. In Botswana, South Africa, and Zimbabwe — countries that would have reduced crude death rates to developed country levels of 5 to 7 per 1,000 before AIDS — crude death rates are projected to range from 30 to 36 per 1,000 by 2010.

Infant and child mortality rates are already higher than they were in 1990 in most countries with severe epidemics, and will continue to increase through 2010. The enormous differences between the HIV/AIDS epidemics in sub-Saharan African countries and the rest of the world are echoed within the continent of Africa itself, where the highest and lowest adult HIV prevalence levels in the world may be found. In Algeria, Egypt, Libya, Mauritania, Morocco and Western Sahara, and Tunisia, national prevalence levels are well below 1 percent. At the opposite end of the continent is Botswana, with the world's highest national reported rate of 36 percent.

With the exception of Côte d'Ivoire and Central African Republic, where national seroprevalence rates are above 10 percent, West and Central African countries have much lower rates than their Eastern and Southern African neighbors. Rates, in turn, are lower in eastern than in southern Africa, with the exception of Rwanda. While Angola reported a seroprevalence of 2.1 percent in mid-1998, the civil war and large numbers of displaced persons make this statistic unreliable.

HIV/AIDS epidemic mortality is changing social and economic life in all sub-Saharan African countries, but effects are particularly severe in seven sub-Saharan African countries where infection

levels in the general population are now greater than 20 percent. In countries with recent civil strife, including Angola and Rwanda, infection levels are likely to be higher than reported. Infection levels in some major cities exceed even the highest national averages.

Infection levels will remain high in most of these countries through 2010, according to the U.S. Census Bureau. While incidence (new cases) is projected to decrease slightly, adult seroprevalence (total cases) will continue to increase in all but three countries with very high infection levels (Republic of Congo, Uganda, and Zambia). In those countries, prevalence levels will plateau or decrease slightly by 2010.

Uganda was the first country to experience a downturn in prevalence in 1995, when its nationwide HIV prevalence level was 12.4 percent. By 2010, seroprevalence will be 8.23. This is still very high by world standards, but lower than most Eastern and Southern African countries. The Democratic Republic of Congo is projected to peak in 2009, when 9.28 percent of all adults will be HIV-positive. Zambia's seroprevalence is believed to have reached a plateau at slightly more than 19 percent in 1998, where it is projected to hover through 2010.

The dynamics of individual countries' HIV/AIDS epidemics are quite different, and include factors related to epidemiology and biology such as the virus genotype, the size of the reservoir of people who are HIV-positive, and the behavior of infected persons. Factors related to human systems, including health care and education, also play a role. They determine health levels of the susceptible population and the nature and extent of services available to infected persons, such as testing, diagnosis, and counseling. These factors interact in complex ways, and in some, they cannot be readily predicted given our current knowledge of HIV/AIDS. For example, while the plateau of the epidemic in Zambia has been well documented with sentinel site and population surveillance data, it was not predicted in the mid-1990s. Uganda's decline has also been documented, and a complex array of contributing factors identified.

Other explanations have to do with economic, social, and cultural differences. Although an economic explanation seems tenuous given the high levels of income of some of the most infected countries, large proportions of the population of those countries live below the poverty line. The concentration of wealth in Botswana, Namibia, South Africa, and Zimbabwe is among the highest in the world, so average per-capita GNP obscures large internal differences within these countries.

Experts have also attempted to explain differences between countries in terms of social and cultural practices. Australian demographers Jack and Pat Caldwell and the Nigerian demographer I.O. Orubuloye have highlighted the coincidence of male circumcision and lower HIV rates, identifying a "noncircumcision belt" traversing the countries of Eastern and Southern Africa that coincides with high rates of HIV prevalence. While geographic correspondence does not represent proof of causality, male circumcision contributes to improved personal hygiene and correlates at the clinical level with lower rates of sexually transmitted infections. They also noted the relatively low rates of HIV infection among Muslim countries of North Africa and in Muslim populations within highly infected countries in West, Central, Eastern, and Southern Africa.

The low social position of women also plays a role in reducing women's access to employment and education, and increasing their vulnerability through commercial sex and lack of power in all sexual relationships. The correspondence of high female responsibility (indicated by a high proportion of female-headed households), and low female authority (indicated by lack of legal majority, inability to own property or land, and subservience to male decision-making) with high levels of HIV prevalence is particularly striking.

The movement of groups of people has always played a role in the spread of human epidemics. New data from countries in Southern Africa suggest a slightly different pandemic history than previously portrayed. When HIV/AIDS projection models are applied, it appears that Southern African countries formerly believed to have been

without HIV/AIDS in the late 1980s and early 1990s already had substantial infection levels by that time. This early spread was fueled by labor migration, wars for independence in Namibia, civil war in Mozambique, and the national struggle against apartheid in South Africa. Each of these events resulted in massive movements of refugees into neighboring countries.

For example, in Mozambique, refugees moved into neighboring Malawi, Zambia, and Zimbabwe, where epidemic levels were already high. Upon resettlement, they brought the HIV levels of their countries of refuge home with them.

Wars of liberation and refugee movements also fueled epidemic spread in the East African countries of Burundi, Rwanda, and Uganda. All of these struggles involved Tanzania, which was also a refuge for freedom fighters from the southern part of the continent. Wars in the Horn of Africa have pushed refugees to Kenya and beyond, and ongoing border skirmishes between Sudan and Uganda continue to contribute to epidemic spread. The crises of the 1990s in countries such as Burundi, Democratic Republic of Congo, Eritrea, Ethiopia, Liberia, and Sierra Leone, are undoubtedly contributing to further spread of HIV/AIDS.

Armies in sub-Saharan Africa and other parts of the world are known to have very high rates of sexually transmitted infections and HIV, which also contribute to epidemic spread. This effect was first seen in Uganda in 1988, where it has long been hypothesized that civil war contributed to the early appearance of the epidemic. The maps below show some of this movement, and also illustrate the difficulty of capturing the complexity of population movements over the past 20 years.

Large-scale labor migration for work in the mines of South Africa has been suggested as a major explanatory factor in epidemic spread in Southern Africa. Poor men from neighboring countries sought work in mines in South Africa and Zambia in the 1970s, 1980s, and 1990s under conditions that fostered the spread of HIV. Migration also fueled epidemics within South Africa and Zambia. Emerald and diamond mines in the Democratic

Republic of Congo and diamond mines in Sierra Leone also fuel conflict on the continent.

The presence of these mines contributed to the rapid spread of HIV, not only through large-scale labor migration, but also by distorting income distribution, increasing dependency on world markets, and reducing the drive to create employment for large underclasses. As a result, in many heavily infected countries with significant mining activity, the proportion of the population in extreme poverty is close to or better than 50 percent.

## Gender Shifts Are More Apparent in Sub-Saharan Africa

The epidemic in sub-Saharan Africa is worse than in other regions because the major route of HIV transmission is heterosexual contact. According to UNAIDS, a growing proportion of AIDS-related deaths in 1999 (44 percent) in sub-Saharan Africa occurred among women. This compares with 30 percent in South and Southeast Asia and 31 percent in the Caribbean, the next highest regions. Current estimates by UNAIDS also show that there are more women (53 percent) living with HIV/AIDS in sub-Saharan Africa. The next highest regions are South and Southeast Asia, at 34 percent, and the Caribbean, at 36 percent. These data also suggest that high female responsibility and low authority have contributed greatly to rapid spread of HIV in sub-Saharan African populations.

The most compelling data concerning the ratio of male and female infections comes from 15 recent population-based HIV-prevalence surveys in various countries in sub-Saharan Africa. Continent-wide, UNAIDS estimates that 12 African women are infected for every 10 men. This research also suggests that the high prevalence levels recorded at antenatal surveillance sites may understate the real levels of HIV infection among women. HIV-positive women have a harder time becoming pregnant or maintaining a pregnancy, and are therefore less likely to go to a clinic for care. On the other hand, the population-based studies show that infection levels among men are probably lower than prevalence levels at antenatal surveillance sites. Armed

with this data, UNAIDS has adjusted its most recent round of estimates of people living with HIV.

The ratio of male-to-female adult infections varies among countries and over time. In the early stages of a heterosexual epidemic, such as those found in Africa, more men are infected than women because men contracted HIV through relationships with commercial sex workers, and subsequently infected their wives. This ratio changes gradually as more men die and more younger women are infected. Women are infected at younger ages than men, but may live longer because they are younger at the time of infection. Recent studies in several places in Africa show that women between ages 15 and 19 are five to six times more likely to be infected than men in the same age group.

Gender inequities work in tandem with rural isolation, poverty, and a host of other social and cultural factors to create an environment conducive to the spread of HIV/AIDS. Twenty years ago, when the first AIDS cases were reported in Africa, the health of the poor had been undermined by insufficient or inconsistent food and water supplies and limited access to health care. Sexually transmitted diseases were widespread and often went untreated. Ability to respond to the threat of HIV was hindered by a lack of access to information and resources, and by the common perception that AIDS was just another health crisis among many. Though HIV/AIDS intervention efforts throughout the 1980s and into the 1990s emphasized individual behavior change, a key lesson learned was that HIV/AIDS must be addressed in a broader, multisectoral development framework, not by the health sector alone.

## USAID's Role

Since 1997, the USAID Africa Bureau and Missions have taken several steps to better understand and cope with the HIV/AIDS pandemic. In early 1999, USAID Health, Population and Nutrition officers from Southern Africa convened a landmark "Storm Warning Meeting" to discuss how to accelerate HIV/AIDS programs in the region and mobilize additional resources for the pandemic. To address high HIV transmission

rates along truck routes, the group developed cross-border programs, a government policy review program to evaluate the movement of goods and services across borders, and an evaluation program. The group continues to meet at least twice a year to review results and plan new regional initiatives.

Following the Storm Warning Meeting, USAID Africa Bureau and Missions adopted a multisectoral program to combat HIV/AIDS, which mobilized stakeholders in agriculture, democracy and governance, microenterprise development, and economic growth. As a result, multisectoral advisory groups were established to foster coordination between missions and ministries of health in sub-Saharan Africa. Missions are also focusing on developing initiatives with faith-based organizations, addressing the needs of orphans and vulnerable children, reducing stigma and discrimination, building the capacity of nongovernmental organizations, developing care and support systems, and strengthening monitoring and evaluations systems.

Through the Leadership and Investment in Fighting an Epidemic (LIFE) initiative, USAID made additional HIV/AIDS funds available for Africa and India in 2000, effectively doubling HIV/AIDS resources in each participating country. In late 2000, the Africa and Global Bureaus prepared a "Strategy for an Expanded Response to HIV/AIDS" to map out program priorities for an expected \$300 million funding allocation in 2001. During 2001, the USAID Africa Bureau will assist missions in "rapid scale-up" or "intensive focus" countries in developing expanded strategies for new HIV/AIDS funding, and will assist "basic countries" in deciding how to program their funding more strategically. The Bureau will also continue to respond to worsening epidemics affected by population shifts and conflicts across the continent.

## Regional Initiatives

The Family Health and AIDS Prevention Activity for West and Central Africa (FHA-WCA) is a USAID-funded partnership among 10 African regional nongovernmental organizations and four U.S.-based private voluntary organizations. It



focuses on key interventions that complement and leverage those interventions of other major donors in seven countries in the region: Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Mali, Senegal, and Togo. FHA-WCA also links USAID-bilateral activities in Benin, Democratic Republic of Congo, and Senegal to its regional initiatives.

The Regional Economic Development Services Office for East and Southern Africa (REDSO-ESA) focuses on enhancing regional capacity to improve health systems, through strengthening regional institutions, enhancing policy dialogue, and supporting training institutions to improve technical capacity. REDSO is funding the Commonwealth Regional Community Health Secretariat, representing 14 African Ministries of Health, to develop a 5-year HIV/AIDS regional strategy and resource mobilization plan. In 2001, REDSO will support a training needs assessment in nine African countries, to be carried out by the Centre for African Family Studies, and will fund additional training courses in HIV/AIDS prevention and care based on the findings of that study. REDSO will also expand its current work to strengthen financial health systems in the region by including HIV/AIDS in National Health Accounts.

The Africa Bureau/Sustainable Development Division cofunded an April 1998 regional conference on men's participation in health care in Burkina Faso. The Bureau also supported training of 10 senior-level radio and print journalists in West Africa under the media activity, Pop'Mediafrique. As a result of the training, the journalists are covering health issues, including HIV/AIDS, more fully and objectively, and regional media organizations have adopted new programs and strategies to reach a wider audience with health and HIV/AIDS information.

Building on the Africa Bureau/Sustainable Development-supported operations research, the Horizons Project has worked to integrate treatment of sexually transmitted infections into other health services, holding national meetings with ministries of health in Botswana, Kenya, and Zimbabwe. The Africa Bureau sponsored a workshop on HIV/AIDS education in South Africa, and strategic planning workshops were organized for nine southern Africa countries.

Several studies on cost-effective HIV/AIDS prevention and mitigation strategies continued or began in 1998. The Horizons project continued its studies of the effectiveness of integrating HIV/AIDS prevention services in maternal and child health/family planning programs. The International Centre for Migration and Health began to replicate the Ugandan analysis of behavior change interventions in Kenya, Malawi, and Zambia, and the Network of AIDS Researchers in East and Southern Africa began operations research on interventions to reduce mother-to-child transmission. The Centers for Disease Control and Prevention studied HIV/AIDS-related socioeconomic impacts with the Measure, Horizons, and Policy projects.

Additional USAID-supported regional initiatives include 1) the Policy Project, which has developed and presented the AIDS Impact Model in seven African countries; 2) the Civil Military Alliance to Combat HIV/AIDS, which has developed three subregional networks to foster cooperation between civilian and military sectors to prevent and mitigate the impact of HIV/AIDS; and 3) the Measure Project, which has helped African epidemiologists to review, summarize, and report their country's current HIV/AIDS evaluation methods and practices.

## Angola

Due to the isolating effects of a recent civil war, Angola's HIV prevalence has remained lower than the infection rates of neighboring Congo, Namibia, Zambia, and Zimbabwe. However, Angola was one of three African countries to experience an increase in HIV prevalence of more than 100 percent between 1994 and 1997.

At the end of 1999, approximately 150,000 Angolan adults were living with HIV/AIDS, yielding an adult prevalence rate of 2.8 percent. In the city of Luanda, 18 percent of sex workers tested positive for HIV in a 1999 study. Fifty-eight percent of sex workers reported never using condoms.

A host of factors are fueling the spread of the epidemic in Angola, including movement of troops, rural-urban migration, refugee migration in and out of neighboring countries, increasing numbers of sex workers, a high incidence of sexually transmitted infections, limited access to health care facilities due to destruction of the health infrastructure, an increasing number of blood transfusions, and limited condom availability and use.

Approximately 30 to 40 percent of Angolan infants born to HIV-positive mothers will also become infected with HIV. Six percent of AIDS cases occur in children under age 5, and mother-to-child transmission accounts for about 11 percent of all HIV infections. An estimated 98,000 Angolan children had been orphaned by AIDS as of 1999.

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**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 160,000

**Total Population:** 12.5 million

**Adult HIV Prevalence:** 2.78%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 19.4%

Population at Low Risk: 3.4%

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### USAID Strategy

USAID began HIV/AIDS-specific programming in Angola in 2000. Programs will focus on condom social marketing and HIV/AIDS information, education, and communication activities targeted to high-risk groups.

The Programa Nacional de Luta contra o SIDA, in collaboration with UNAIDS, recently developed a multisectoral response to the epidemic.

### USAID-Supported Programs

Population Services International/AIDSMark has launched a two-year pilot project in condom social marketing in Angola aimed at sex workers, youth, and other high-risk groups. Activities include the introduction of a new condom brand in spring 2001, and mass media and interpersonal communications initiatives, including peer education, workplace interventions, and outreach teams to visit sex workers in hotels and brothels to provide counseling on condom use.

## Benin

As in many West African countries, Benin's overall HIV prevalence remains relatively low, but the disease is spreading steadily among young adults and in high-

risk populations. In 1999, the Ministry of Health reported that an estimated 159,216 adults and children in Benin were living with HIV/AIDS. About 37,141 children under age 15 had been orphaned by the disease. The 20- to 39-year-old age group accounted for 67 percent of AIDS cases reported in 1999, and heterosexual transmission was linked to the vast majority of these cases (90 percent). The Health Ministry estimates that in Benin, women account for about 40 percent of all persons living with HIV/AIDS.

HIV prevalence ranges from 0 to 14 percent in pregnant women, and from 4 and 32 percent among patients with sexually transmitted infections. Recent Ministry of Health studies (1999) show a prevalence of about 54 percent among sex workers.

The HIV epidemic in Benin has had a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others. Many infants born to HIV-positive mothers will become infected with HIV; most will die within two years. Benin's infant mortality rate is estimated to be lower than that of other sub-Saharan African nations (86 per 1,000 live births, according to 1999 UNICEF estimates). In 1999, an estimated 3,000 Beninese children were living with HIV/AIDS.

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**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 70,000

**Total Population:** 5.9 million

**Adult HIV Prevalence:** 2.45%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 60%

Population at Low Risk: 4.1%

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### USAID Strategy

USAID/Benin is working to increase the use of HIV and sexually transmitted infection services and prevention measures within a supportive policy environment. Specifically, the Mission strives to increase access to services and products; improve the quality of management and prevention services; and increase the demand for practices supporting the use of these services, products, and prevention measures.

In 1999–2000, USAID/Benin developed a strategy for a new national HIV/AIDS prevention program, which focuses on advocacy, epidemiological and behavioral surveillance, sexually transmitted infection treatment, behavior change communication for high-risk groups, and continued support for condom social marketing. The Mission will also support the National AIDS Control Program in its efforts to coordinate the newly developed national AIDS prevention strategy. USAID/Benin expects that its new strategy will be implemented in 2001.

### USAID-Supported Country Programs

USAID/Benin's condom social marketing program, implemented by Population Services International/AIDSMark, is currently USAID's major national HIV/AIDS prevention activity. Condom sales have doubled since 1997, with more than 6 million condoms sold in fiscal year 1999. By the end of 1999, there were nearly 7,000 sales points for condoms in Benin, up from 2,500 in 1997. Benin also participates in Population Services International's regional social marketing and behavior change program, which targets migrant populations, such as truckers.

Since 1998, the Mission has supported a variety of information, education, and communication-

related activities, including training of outreach workers to promote HIV and sexually transmitted infection sensitivity, and the production and broadcasting of films and plays about HIV/AIDS-related topics. USAID has also supported capacity building of the national AIDS journalists network and the national AIDS research network. In addition, USAID financed the development of advocacy tools that can be used to influence decision-makers, and provided support to the National AIDS Control Program to improve management capacity and clarify the program's coordinating role.

## Democratic Republic of Congo

UNAIDS estimates that 1.1 million Congolese were living with HIV/AIDS at the end of 1999, yielding an adult prevalence of more than 5 percent. The three main modes of transmission for new HIV infections are heterosexual contact (87 percent), mother-to-child transmission (8 percent), and blood transfusions (5 percent). The most affected age groups are 20 to 29 for women, and 30 to 39 for men. Life expectancy in the Democratic Republic of Congo dropped 9 percent in the 1990s as a result of HIV/AIDS.

According to UNAIDS, several factors are fueling the spread of HIV in the Democratic Republic of Congo, including movement of large numbers of refugees and soldiers, scarcity and high cost of safe blood transfusions in rural areas, a lack of counseling and few testing sites, high levels of untreated sexually transmitted infections among sex workers and their clients, and low availability of condoms outside

Kinshasa and one or two provincial capitals. Consecutive wars have made it nearly impossible to conduct effective and sustainable prevention activities. In addition, the HIV–tuberculosis coinfection rate ranges from 30 to 50 percent.

The number of Congolese women living with HIV/AIDS is growing. UNAIDS reports that the ratio of new infections changed from 1:6 (women to men) in 1991 to 1:3 in 1997. Infection rates among pregnant women tested in 1999 in Kinshasa ranged from 3 to 5 percent. Presently, no preventive predelivery treatment is available to HIV-infected mothers.

Between 1985 and 1997, infection rates among sex workers in Kinshasa ranged from 27 to 38 percent. More than half (57 percent) of the total population is younger than 15 years old. The AIDS epidemic has had a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others. Approximately 30 to 40 percent of infants born to HIV-positive mothers will become infected with HIV. An estimated 680,000 children have been orphaned by HIV/AIDS since the epidemic began.

### Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:

1,100,000

**Total Population:** 50.4 million

### Adult HIV

**Prevalence:** 5.07%

### HIV-1 Seroprevalence in Urban Areas:

Population at High Risk: 29%

Population at Low Risk: 4.1%

### USAID Strategy

Concurrent with an anticipated increase in resources, USAID/Democratic Republic of Congo

will step up its HIV/AIDS prevention and surveillance activities over the next five years. The Mission will focus on enhancing treatment and community support activities, increasing political and social commitment to HIV/AIDS, and reducing the stigma of persons living with the disease.

USAID/Democratic Republic of Congo currently supports HIV interventions that emphasize prevention (i.e., behavior change communication and condom social marketing). Pending available funds, USAID will support surveillance to fill the current gap in existing HIV seroprevalence and behavioral data, revitalize behavior change communications activities targeting high-risk groups, increase condom social marketing, improve management of sexually transmitted infections, promote care and support activities (including voluntary counseling and testing, prevention of mother-to-child transmission of HIV, and tuberculosis prevention and management), and improve blood safety.

#### **USAID-Supported Country Programs**

Condom distribution programs in the Democratic Republic of Congo, implemented by Population Services International/AIDSMARK, are aimed at high-risk groups in major urban areas such as the police, military, truck drivers, and sex workers and their clients. Currently, approximately 1 million condoms are distributed each month, but the unmet need is high. Condom distribution is complemented by targeted education programs designed to help individuals change high-risk behaviors and provide training in peer education and program monitoring and evaluation. The Centers for Disease Control and Prevention supports the revitalization of 10 sentinel surveillance sites and is considering expanding activities to support voluntary

counseling and testing and mother-to-child transmission interventions.

Christian AID implements voluntary counseling and testing initiatives and provides care and support to people living with or affected by HIV. Partners include the women's organization *Femme Plus* and *Avenir Meilleur pour Orphelins*.

Catholic Relief Services has introduced rapid HIV diagnostic tests to improve blood safety in rural health delivery sites. The United Nations Children's Fund receives USAID support to improve management of sexually transmitted infections.

In an effort to mitigate the Democratic Republic of Congo's high tuberculosis-HIV coinfection rate, USAID supports projects that identify and effectively treat tuberculosis infections among people who are HIV-positive.

## **Eritrea**

The first case of AIDS in Eritrea was reported in 1988. UNAIDS has limited information on the HIV/AIDS situation in Eritrea, but estimates that about 3 percent of the adult population is infected. The National AIDS Control Programme estimates that 60,000 to 70,000 Eritreans are living with the disease.

About 70 percent of reported AIDS cases occur among young adults aged 20 to 39, with 5 percent of cases occurring in children under 15. Heterosexual contact is believed to account for 90 to 95 percent of AIDS cases, while mother-to-child transmission accounts for 5 percent. The majority of cases (98 percent) are found in the urban centers of Asmara, Massawa, and Assab. A 1997 study found that 2 percent of pregnant women attending antenatal clinics were HIV-positive, as

were 35 percent of sex workers. In 1999, the Ministry of Health reported 386 known cases of AIDS orphans in Asmara alone.

<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>	49,000
<b>Total Population:</b>	3.7 million
<b>Adult HIV Prevalence:</b>	2.87%
<b>HIV-1 Seroprevalence in Urban Areas:</b>	
Population at High Risk:	N/A
Population at Low Risk:	3%

#### **USAID Strategy**

While the prevalence of HIV/AIDS in Eritrea is still relatively low compared with many other countries in sub-Saharan Africa, the risk of an epidemic is considered high due to the large number of Eritrean troops aged 18–40 who may soon be demobilized from the Ethiopian border. In addition, about 1 million Eritreans were displaced by the military offensive launched in May 2000. Given this high-risk situation and early recognition of the threat by the Government of Eritrea, USAID/Eritrea is rapidly expanding support from condom social marketing to other aspects of HIV/AIDS prevention and care.

#### **USAID-Supported Country Programs**

USAID/Eritrea has supported an HIV/AIDS prevention condom social marketing program since 1997. During FY 2000, the Mission and the Ministry of Health designed and funded new initiatives in behavior change communications, care and support of people living with AIDS, voluntary counseling and testing, treatment and prevention of sexually transmitted diseases, and surveillance.



## Ethiopia

Ethiopia is one of the sub-Saharan African countries hit hardest by HIV/AIDS, with an infection rate of 10.6 percent in the adult population. At the end of 1999, about 2.9 million adult Ethiopians were living with HIV/AIDS.

Using U.S. Census Bureau data, the United Nations Development Programme estimates that life expectancy in Ethiopia will decline to about 42 years due to AIDS by 2010; without AIDS, life expectancy would be 55 years.

According to the Ethiopian Ministry of Health, blood transfusions, unsafe injections, perinatal transmission, and sexual contact are the four predominant modes of HIV transmission. Currently, 87 percent of all HIV/AIDS infections result from heterosexual transmission. The recent Demographic and Health Survey (preliminary report) found that 17 percent of women and more than 35 percent of men mentioned condoms as one way to avoid infection; however, less than 2 percent of all men and less than 1 percent of all women currently use condoms.

As of October 1997, men comprised about 61 percent of reported AIDS cases, while women accounted for about 39 percent. HIV prevalence among pregnant women in Addis Ababa increased from 5 percent in 1989 to 18 percent in 1997.

As of 1999, 56 percent of the Ethiopian population was under age 15 and about 150,000 children under age 15 were living with HIV/AIDS. Reversing years of progress in child survival, AIDS increased Ethiopia's infant mortality rate by 7 percent from 1995 to 2000. According to the Ministry of Health, at the end of 1999, an estimated 750,000 Ethiopian children had been orphaned due to HIV/AIDS.

Most HIV infections in Ethiopia occur among young people in their teens and 20s, and young women are particularly vulnerable. The number of HIV-positive women in the 15- to 19-year-old age group is much higher than the number of HIV-positive men in the same age group. This is due to earlier initiation of sexual activity by women and the fact that their older partners often have more than one sexual partner.

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<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>	<b>3 million</b>
<b>Total Population:</b>	<b>61 million</b>
<b>Adult HIV Prevalence:</b>	<b>10.63%</b>
<b>HIV-1 Seroprevalence in Urban Areas:</b>	
Population at High Risk:	<b>73.7%</b>
Population at Low Risk:	<b>17.6%</b>

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### USAID Strategy

With the passage of the government's Health Care Financing Strategy and National HIV/AIDS Policy, USAID is mobilizing to increase resources to the health sector and make a concerted effort to confront the AIDS epidemic in Ethiopia.

The Mission has supported various information, education, and communication efforts to promote HIV/AIDS prevention, including campaigns focusing on transportation workers and passengers, and the development of integrated prevention, diagnosis, and treatment of sexually transmitted infections in urban areas.

In addition to providing funding to the Ministry of Health National AIDS Control Program office to carry out basic programming, USAID supports cooperating agency activities to strengthen public and nongovernmental organization

capacity and participation; integrate prevention and control of HIV and sexually transmitted infections into health programs at the national, regional, and local levels; and promote a nationwide Family Life Education curriculum.

### USAID-Supported Country Programs

Currently, USAID supports a variety of public and private sector initiatives in the fight against HIV/AIDS. The Policy Project works with both the World Bank and the Ministry of Health, particularly the National AIDS Secretariat and the National AIDS Council, in setting policy guidelines and carrying out advocacy and monitoring and evaluation of the National AIDS program.

Pathfinder currently funds nongovernmental organization partners in a variety of activities. As part of its faith-based initiative, the Ethiopian Orthodox Church, the Evangelical Church, and the Ethiopian Islamic Affairs Supreme Council have received support to raise HIV awareness and extend care and support services to the general population. Funding has been given to the Confederation of Ethiopian Trade Unions and the Addis Ababa Chamber of Commerce for workplace HIV/AIDS programs. Pathfinder is also working with high-risk groups (sex workers and truckers) to implement both preventive and mitigation measures. Work with the public sector has included the development of a national HIV/AIDS home-based care services training curriculum, followed by a training-of-trainers curriculum.

PACT supports organizations working with street children and children affected by AIDS. Issues of democracy and governance, including the rights of people living with HIV/AIDS and the rights of children orphaned due to AIDS, are also being addressed.

Population Services International/DKT has a vibrant social marketing program that sold more than 46 million condoms in 2000. DKT sold approximately 12 million condoms to the military alone in the first 10 months of 2000. During the same period, DKT conducted five training programs on HIV awareness and on proper and consistent use of condoms for military personnel posted in border areas. DKT also produced a two-hour film with the military on protecting their families from HIV/AIDS. With the initiation of the demobilization process, the military requisitioned an additional 60,000 condoms and HIV/AIDS information/education materials from DKT.

## Ghana

According to the Ministry of Health, an estimated 430,000 adult Ghanaians were living with HIV/AIDS at the end of 1999, yielding an adult infection rate of 4.6 percent. Approximately 180,000 adult women are living with the disease.

The migration of Ghanaian women to find work has played a significant role in the increased incidence of HIV infection in Ghana. Female sex workers migrating to Côte d'Ivoire, which has the highest HIV prevalence in West Africa, is of particular concern. Some reports indicate the ratio of men to women infected when the epidemic began was as high as 1:6. The incidence is now increasing among Ghanaian men, bringing the ratio of men to women to 1:2. In 1997, HIV prevalence among sex workers in Accra was 75.8 percent. Prevalence among pregnant women in major urban areas was 2 to 7 percent in 1998; outside of major urban areas, HIV prevalence ranged from 2 to 12 percent of all pregnant women.

More than 90 percent of men and women are aware of HIV/AIDS transmission mechanisms. However, major behavioral changes needed to slow transmission rates have not yet occurred. The high rate of HIV infection among women has led to a vast increase in pediatric HIV/AIDS prevalence. As of June 1998, 387 pediatric AIDS cases had been reported. Approximately 85 percent of Ghana's pediatric cases are attributed to mother-to-child transmission, and drugs used to prevent this mode of transmission are not available. The remaining 15 percent of pediatric cases are attributed to contaminated blood transfusions and equipment.

UNAIDS estimates that of 9.9 million children under age 15 in Ghana, 14,000 are living with HIV/AIDS and 170,000 have become orphans due to AIDS since the epidemic began. Most HIV/AIDS cases in Ghana occur in young people. Peak ages for AIDS cases are 30–34.

<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>	340,000
<b>Total Population:</b>	19.7 million
<b>Adult HIV Prevalence:</b>	3.6%
<b>HIV-1 Seroprevalence in Urban Areas:</b>	
Population at High Risk:	72.6%
Population at Low Risk:	2.7%

### USAID Strategy

USAID/Ghana's HIV/AIDS strategy focuses on behavior change among high-risk groups, as well as developing local capacity for diagnosis and surveillance of HIV and other sexually transmitted infections. The Mission supports the training of health workers in

improved detection and treatment of sexually transmitted infections, strengthening laboratory support and surveillance, and social marketing of condoms.

With USAID support, Ghana has developed one of the most advanced national sentinel surveillance systems for HIV and sexually transmitted infections in Africa. The system includes four public health reference laboratories built, equipped, and staffed by laboratory personnel trained under the USAID-supported program. The Mission provides grants to local and U.S. private voluntary organizations to strengthen the capacity of the National AIDS Control Program and the National Public Health Reference Laboratory.

USAID has also supported development of a national strategic framework for HIV/AIDS and a draft national HIV/AIDS policy, which is awaiting government approval. The Ghana AIDS Commission was established in September 2000 to advocate for HIV/AIDS programs at all levels of government, incorporate HIV/AIDS activities into other sectors, and mobilize resources for HIV/AIDS programs. Additional USAID-supported activities include the development and revision of the 1999 National AIDS Impact Model and revision of the national essential drugs list and National Formulary.

USAID is working with the Ministry of Education to integrate HIV/AIDS into school curricula by providing assistance in the development of a strategic plan and on the evaluation of ongoing activities within the Ghana Education Service.

### USAID-Supported Country Programs

Family Health International/IMPACT implements several HIV/AIDS programs in Ghana.

Working with the Ministries of Health and Defense, Family Health International has trained approximately 250 medical officers in counseling and sexually transmitted infection syndromic management, 65 police officers in peer education, and 87 military officers in HIV education and counseling. Hospital laboratory staff have also been trained in quality assurance testing for HIV and sexually transmitted infections. With Family Health International grant money, the Salvation Army has trained more than 90 peer educators in counseling and home-based care, and the Red Cross has trained 36 youth educators in Kumasi.

The Ghana Social Marketing Foundation initiated a "Stop AIDS, Love Life" public education campaign in February 2000, and has sold an average of 800,000 condoms a month since the campaign began, almost doubling monthly sales. USAID/Ghana guided the high-profile, multimedia campaign, which included radio and television announcements and testimonials by people with AIDS. Ministry of Communication audiovisual vans provided information on HIV/AIDS to Ghanaians in 1,100 rural villages and towns in all 10 regions. In addition, road shows toured 110 towns and cities throughout the nation.

To complement the campaign, the Ghana Social Marketing Foundation and the U.S. Peace Corps have developed a behavior change activity aimed at truckers in six major transportation hubs. Advocacy and sensitization workshops have been conducted with local transport executives, and peer education training for Peace Corps volunteers is underway. The Ghana Social Marketing Foundation has also trained more than 1,800 hairdressers and 800 barbers in HIV/AIDS prevention communication.

## Guinea

The Government of the Republic of Guinea reports that HIV prevalence ranges between 2.2 percent and 4.1 percent. According to UNAIDS, an estimated 52,000 adult Guineans were living with HIV/AIDS at the end of 1999, equaling 1.5 percent of the 15-and-older population. Fifty-six percent of these cases were women. It is important to note that the Government of Guinea has not conducted a national seroprevalence survey and has stated that it has no reliable data on HIV/AIDS.

According to the 1999 Demographic and Health Survey, 95 percent of women and 96 percent of men had heard about AIDS, but 30 percent of all respondents cited erroneous prevention information or said they knew of no way to stop the spread of AIDS. Only 27 percent of men and 18 percent of women said they used condoms with nonregular sex partners.

HIV prevalence among pregnant women in Conakry, Guinea's major urban area, ranged between 1 percent and 2 percent as of 1996. In 1994, 37 percent of sex workers tested in Conakry were HIV-positive, and in 1995, 5 percent of patients with sexually transmitted infections tested positive for HIV.

UNAIDS reports that of the 3.3 million children under age 15 in Guinea, about 2,700 are living with HIV/AIDS. Approximately 30,000 Guinean children have become orphans due to AIDS since the epidemic began.

Most HIV/AIDS cases in Guinea occur in young people. The peak age group is 20 to 39, which accounted for 77 percent of total AIDS cases as of 1998.

<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>	55,000
<b>Total Population:</b>	7.3 million
<b>Adult HIV Prevalence:</b>	1.54%
<b>HIV-1 Seroprevalence in Urban Areas:</b>	
Population at High Risk:	36.6%
Population at Low Risk:	1.5%

### USAID Strategy

USAID/Guinea plans to expand its emphasis on combating HIV/AIDS. The goal will be to maintain the country's low seroprevalence by implementing a multisectoral approach focused on primary prevention. USAID will follow a plan emphasizing men and groups who practice high-risk behavior and will continue to stress behavior change among the general population. A major effort will be made to collaborate with partners already active in HIV/AIDS prevention and mitigation.

USAID will also target decision-makers at all levels of Guinean society (e.g., politicians, religious leaders and community leaders) to create and reduce stigma and discrimination and to strengthen HIV/AIDS advocacy efforts. USAID, along with the World Bank, the World Health Organization, and the United Nations Children's Fund, will assist the Programme Nationale Lutte Contre le SIDA by strengthening its capacity to monitor the epidemic, beginning with a national seroprevalence survey to be conducted by the end of 2001.

### USAID-Supported Country Programs

USAID works to ensure that services and information on HIV/



AIDS and sexually transmitted infections are widely available across Guinea. The integration of prevention and care services into health centers is a major focus of USAID programming; the Mission recently teamed with the World Bank to improve the quality of sexually transmitted infection services in health centers. Service providers are being trained in service delivery, including the syndromic approach, as well as in supervision, counseling, and referral. Improving the drug distribution system for treatment of sexually transmitted infections is also a high priority.

USAID social marketing programs are active in Guinea. As a result, condoms are now available in 89 percent of Guinean subprefectures. In addition, community-based distributors are trained to provide HIV/AIDS information and sell condoms.

Information, education, and communication activities are also being implemented, with a special emphasis on high-risk groups such as adolescents, the military, and miners. To reach a cross-section of Guineans, USAID-funded programs have enlisted the help of musicians and religious and community leaders in promoting HIV/AIDS awareness. Specific information, education, and communication activities include rural radio soap operas, radio call-in-shows, rock concerts, religious videos, workshops, sales promotions, and sports events.

## Kenya

UNAIDS reports that Kenya is one of nine African countries hit hardest by the HIV/AIDS epidemic. At the end of 1999, an estimated 2 million Kenyan adults were living with HIV/AIDS, representing a prevalence rate of 14 percent. Due

to AIDS, the crude death rate in Kenya is 105 percent higher in 2000 than it was in 1990. Life expectancy dropped from 59 years in the 1980s to 49 years in 1998.

The peak ages for HIV infection in Kenya are 25 to 29 for women and 30 to 34 for men. Girls and young women are particularly vulnerable to infection; a high age differential between regular male and female partners is often cited as a contributing factor to rising HIV incidence among Kenyan women. Young women aged 15 to 24 are more than twice as likely to be infected as men in the same age cohort. According to sentinel surveillance data gathered in 2000, HIV prevalence among pregnant women exceeded 20 percent at nine sites throughout Kenya. Eight additional sites reported HIV prevalence rates of 10 to 20 percent among pregnant women.

Approximately half the Kenyan population carries a latent tuberculosis infection. In the past decade, the HIV/AIDS epidemic has helped to triple the number of new adult tuberculosis cases in Kenya.

UNAIDS estimates that 730,000 children had lost their mother or both parents (while they were under the age of 15) to AIDS by the end of 1999. AIDS is also believed to be the major cause of child death in Kenya, having surpassed other major contributors such as measles and malaria. Reversing years of progress in child survival, AIDS will increase Kenya's infant mortality rate by 44 percent by 2015.

A number of studies from Kenya's Ministry of Health indicate that high health care costs and lost income from HIV/AIDS will be a major burden on the Kenyan economy. By 2005, Kenya's gross domestic product is projected to be 14.5 percent lower than it would have been in the absence of AIDS.

**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 2.1 million

**Total Population:** 29.5 million

**Adult HIV Prevalence:** 14%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 74.7%

Population at Low Risk: 15.9%

### USAID Strategy

USAID/Kenya's HIV/AIDS program focuses on support for prevention and behavior change, policy and advocacy, and community-based care. In fiscal year 2000, the USAID/Kenya budget for HIV/AIDS was \$6.9 million. For fiscal year 2001, the Mission anticipates an increase to \$11.5 million. This level includes funds from the following accounts: HIV (\$8.412 million), tuberculosis (\$0.987 million), and orphans and vulnerable children (\$2.095 million).

### USAID-Supported Country Programs

#### Behavior change

To reduce sexual transmission and encourage positive personal behavior change, USAID is working nationwide with local groups to establish interpersonal and peer counseling programs, communication campaigns, community outreach through peer motivation, participatory meetings, and community theater. USAID supports existing networks to provide leadership for HIV/AIDS prevention and care, including church-affiliated groups and groups representing persons living with HIV/AIDS. USAID programs improve voluntary counseling and testing through developing curriculum, testing protocols, and updating national guidelines. USAID supports distribution of public sector



condoms and sexually transmitted infections and tuberculosis drugs through the government's logistics management system. Programs work with businesses to develop supportive policies and prevention and care programs for workers. Community-level programs target sites where populations at high risk for HIV infection live or work (e.g., sugar plantations, border towns, large factories, and other settings with high rates of commercial sex). In general, interventions in priority communities include activities to create a supportive environment for personal behavior change through peer education targeting highly vulnerable women, workplaces, and schools. In addition, USAID is upgrading sexually transmitted infection clinics, improving clinic-based HIV/AIDS care, and establishing tuberculosis diagnostic centers and voluntary counseling and testing centers in existing service delivery points.

#### ***Social marketing***

Since 1990, Kenya's social marketing program has steadily increased the marketing and distribution of TRUST condoms to sales of more than 1 million per month. The program also carries out advertising campaigns to inform people about the safety of condoms, the dangers of cross-generational sex, and sex with multiple partners.

#### ***Blood safety***

In addition to helping develop a national blood policy, USAID is assisting the Government of Kenya to revamp its blood transfusion system through building and renovating five transfusion centers, providing equipment to three others, and training technical staff.

#### ***Research, policy, and advocacy***

USAID supports policy and advocacy activities to help overcome key policy constraints that might slow the implementation of the national HIV/AIDS control program. Activities include working with nongovernmental organiza-

tions to develop advocacy strategies for promoting HIV/AIDS prevention education for adolescents, working with parliamentarians and training senior officials to understand the epidemic and become advocates for strong government and nongovernmental organization programs to combat HIV/AIDS, building national-level government capacity to improve analysis of sentinel surveillance data, preparing advocacy materials and undertaking epidemiologic projections, building capacity at the district level and among private sector networking institutions and the uniformed services to provide leadership for AIDS prevention and care, and conducting behavioral surveillance surveys.

#### ***Mother-to-child transmission***

USAID has partnered with the Kenyan government, the United Nations Children's Fund, and African researchers to undertake pilot interventions to prevent mother-to-child transmission of HIV. These pilot sites offer improved antenatal care services, integrated HIV/AIDS counseling and testing with existing health services, and as appropriate, antiretroviral prophylaxis.

#### ***Community-based care and support***

The community-based care and support program works to improve the ability of local communities to identify their needs and to develop and carry out activities focused on home-based care and support for persons living with HIV/AIDS and their families. USAID undertakes programs to improve tuberculosis diagnosis and treatment services in selected sites.

#### ***Other programs***

Recognizing that AIDS is not just a health problem, USAID is attempting to work cross-sectorally in both the microfinance and democracy and governance sectors. USAID is supporting a microenterprise organization to develop the

capacity of local grassroots savings and credit organizations to provide financial services to the poor, especially those affected by HIV/AIDS. USAID's just-completed AIDS assessment proposes several strategies for improving synergy and programming across these sectors.

## **Madagascar**

Only 248 HIV cases had been officially reported as of 2000 out of Madagascar's population of more than 15 million, due to underreporting. The actual number of HIV/AIDS cases, however, is believed to be much greater. The sentinel surveillance system, which had not been functional since 1996, was revitalized in October 2000. Preliminary results from the 2000 survey indicate that HIV prevalence among patients with sexually transmitted infections is now more than 1 percent in five out of eight sentinel sites. These new data suggest that Madagascar may now be experiencing an acceleration in the spread of the epidemic.

While HIV rates appear to be relatively low, Madagascar's extremely high rates of sexually transmitted infections may fuel the epidemic in the future. Syphilis rates are as high as 15 percent among pregnant women and 35 percent among sex workers. A recent study among a rural population showed that 26 percent of adults and 21 percent of pregnant women had active syphilis. USAID-funded operations research demonstrates that 82 percent of the women have at least one sexually transmitted infection, and rates of gonorrhea and chlamydia are as high as 34 percent and 26 percent, respectively. High rates of sexually transmitted infections and associated risk behaviors demonstrate an urgent need for expanded prevention efforts that target youth,

sex workers and their clients, and male migrant workers.

Madagascar's extremely high rates of sexually transmitted infections, along with limited access to health and social services and widespread poverty, provide ideal conditions for the rapid spread of HIV to the general population. Women's low social and economic status, combined with their greater biological susceptibility to HIV, compounds their vulnerability to infection.

In late 2000, the Government of Madagascar took a dramatic turn in its commitment to HIV/AIDS prevention when the prime minister established an interministerial, multi-sectoral HIV/AIDS committee. The committee developed a national strategic plan for HIV/AIDS through a participatory process, and each ministry is currently developing an HIV prevention implementation plan. Regional HIV prevention committees are also being established.

UNAIDS estimates that as of 1999, 2,111 Malagasy children were living with HIV/AIDS, and 2,600 children had been orphaned by the disease.

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**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:**

11,000

**Total Population:** 15.5 million

**Adult HIV**

**Prevalence:** 0.15%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: N/A

Population at Low Risk: 0.1%

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**USAID Strategy**

The Mission's conviction that there is a unique opportunity in Madagascar to prevent the spread of HIV was formalized in its 1997 HIV/AIDS strategy. The strategy focused on reducing the rate of

sexually transmitted infections among high-risk populations; and promoting an integrated approach to HIV prevention in six target areas through condom social marketing, behavior change communication, and improved sexually transmitted infection services. In addition, the strategy calls for improving the treatment of sexually transmitted infections and ensuring a consistent drug supply, supporting pilot studies in integrating prevention of sexually transmitted infections and HIV into family planning services, raising awareness among policymakers and the public, conducting research into behavior change messages, and strengthening the capacity in the nongovernmental organization sector.

The Mission is currently revising its HIV strategic framework to complement the new country strategy for 2003–2008. Despite the limited impact of HIV in Madagascar, the Mission is exploring ways to fully integrate HIV prevention across sectors. USAID/Madagascar is reviewing the current HIV/AIDS strategy to inform this process, and conducting a situation analysis to reflect the current status of the epidemic, the Government of Madagascar's response, changes in donor commitment, and lessons learned to date. Intensive efforts to manage and prevent sexually transmitted infections and condom social marketing remain a high priority for the Mission.

In addition, expanding targeted interventions to reach a greater proportion of vulnerable people will continue to be an important component of the strategy. This may include expansion of the geographic scope to emerging "hot spots," such as sapphire and ruby mining, truck routes, and cattle markets, as well focused interventions aimed at male migrants and clients of sex workers.

**USAID-Supported Country Programs**

Specific activities supported by USAID include the following:

- ⊙ Condom promotion and strengthening private sector response to HIV/AIDS through social marketing program/Population Services International;
- ⊙ Improved sexually transmitted infection management through Family Health International/IMPACT and Population Council/Horizons;
- ⊙ Operations research on the female condom through Family Health International;
- ⊙ Improved sexually transmitted infection diagnosis and treatment and targeted interventions with sex workers, truckers, and youth through *Medicins du Monde*;
- ⊙ Integrated sexually transmitted infection prevention and health activities;
- ⊙ Technical assistance at the national level and "hot spot" interventions through John Snow Inc.;
- ⊙ Strengthening nongovernmental organization capacity to design and manage HIV prevention activities through the International HIV/AIDS Alliance; and
- ⊙ Enhanced program monitoring and evaluation, improved data collection, and journalist training through Measure/DHS.

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**Malawi**

The HIV/AIDS epidemic in Malawi is one of the most severe in sub-Saharan Africa. At the end of 1999, the Government of Malawi estimated that about 15 percent of

adults were infected with HIV, or approximately 730,000 people.

According to the World Bank, AIDS is the major cause of death among people aged 15 to 49. From 1990 to 2000, AIDS was expected to raise the crude death rate in Malawi by 44 percent. Life expectancy is estimated to have dropped from 52 to 42 years as a result of AIDS, and according to U.S. Census Bureau projections, it may fall well below 40 by 2010.

HIV began to spread in Malawi in the early 1980s, primarily as a result of multiple partner sexual contact, low condom use, and high prevalence of sexually transmitted infections. Although Malawians initiate sexual activity at an early age, overall condom use remains low. In a 1996 Demographic and Health Survey, 43 percent of men and 24 percent of women reported using a condom during their most recent sexual encounter with a nonregular partner. In the same survey, almost all men (99 percent) and women (97 percent) had heard of AIDS, and most were able to identify at least two ways of avoiding HIV transmission.

Equal numbers of Malawian women and men are likely infected with HIV, although rates are highest among women 25 to 29 years old. In 1997, 13 percent of AIDS cases reported in Malawi occurred among 15- to 24-year-olds, with women outnumbering men by a factor of 3 to 1. Much of HIV transmission occurs from older men to younger women, who find it difficult to negotiate condom use.

In Malawi, where about 44 percent of the population is under age 15, approximately 30 percent of infants born to HIV-positive mothers will also become infected with HIV. During the 1990s, AIDS is estimated to have increased Malawi's infant mortality rate by about 7 percent. In 1999, HIV prevalence among pregnant women in urban areas was 26 percent. At the end of

1999, an estimated 390,000 children had been orphaned by AIDS.

HIV/AIDS is beginning to have a devastating effect on health services in Malawi. In 1996, the annual cost of treating persons with HIV/AIDS was estimated at almost \$2 million, or 7 percent of the Ministry of Health's 1995–1996 budget. According to the World Bank, half of all patients admitted to health institutions are infected with HIV. In addition, absenteeism, illness, and death from AIDS have exacerbated shortages of health care personnel. In the health and education sectors, annual personnel death rates are six times higher than they would have been without AIDS.

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#### **Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:**

**Total Population:** 800,000

**Adult HIV Prevalence:** 9.9 million

**HIV-1 Seroprevalence in Urban Areas:** 15.96%

#### **Population at High Risk:**

**Population at Low Risk:** 70.4%

30.4%

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#### **USAID Strategy**

HIV/AIDS activities are being integrated into USAID health, education, agriculture, and democracy and governance programs. USAID is also an active member of the Government of Malawi and UNAIDS-led Technical Working Group on HIV/AIDS. One of the more successful USAID-supported initiatives in Malawi has been implemented through the Malawi AIDS Counseling and Resource Centre to promote voluntary HIV counseling and testing services. The number of clients tested for HIV at Macro International Inc., jumped from 5,663 in 1999, with

70 percent of clients receiving test results, to 21,000 in 2000, with 99 percent receiving results. Macro International Inc., with the assistance of the Centers for Disease Control and Prevention, introduced a new rapid HIV test in Malawi in January 2000; high-client satisfaction has been reported.

#### **USAID-Supported Country Programs**

Through its cooperating agencies, the Mission supports activities to:

- ⊙ Develop a monitoring and evaluation system for HIV/AIDS, including the supporting data collection and analysis of the 1998 Malawi Population Census and year 2000 Demographic Health Survey;
- ⊙ Provide training in syndromic management of sexually transmitted infections;
- ⊙ Expand HIV prevention services at the community level;
- ⊙ Improve access to voluntary HIV counseling and testing;
- ⊙ Promote employer-based HIV/AIDS prevention programs on agricultural estates;
- ⊙ Increase access to condoms through a national condom social marketing program;
- ⊙ Promote vocational training and income-generating activities for those providing home-based care to persons living with AIDS;
- ⊙ Provide technical assistance for the development of a five-year National HIV/AIDS Framework and National HIV/AIDS Policy;
- ⊙ Provide technical assistance for the development and implementation of policy and advocacy campaigns aimed at key political figures, policymakers, and community and religious leaders;



- ⊙ Support social, psychological, and economic assistance to orphans and vulnerable children and family members who have lost someone to AIDS;
- ⊙ Provide home-based care to terminally ill patients and improve access to health centers for children younger than 5;
- ⊙ Develop a national behavior change intervention strategy and local and national campaigns to promote and sustain behavior change through media;
- ⊙ Support HIV prevention activities for youth both in school and out of school through HIV prevention clubs and teacher training;
- ⊙ Introduce services to reduce mother-to-child transmission of HIV at district and non-governmental organization hospitals; and
- ⊙ Train health workers to improve infection control procedures at health facilities.

## Mali

With an HIV prevalence of about 2 percent, Mali is one of the least affected countries in sub-Saharan Africa. At the end of 1999, an estimated 97,000 adults were living with HIV/AIDS.

UNAIDS estimates that 55 percent of adults aged 15 to 49 living with HIV/AIDS in Mali are women. Among sex workers in Bamako, HIV prevalence dropped from 39 percent in 1987 to 23.1 percent in 2000. Prevalence rates among sex workers in other regions increased from 16 to 47 percent over the same time period. In Bamako, prevalence among women attending antenatal clinics increased from 1 percent in 1987 to 4 percent in 1994.

Female genital cutting is a common practice in Mali, despite active campaigns to end the practice. According to a 1997 USAID-funded study of more than 9,000 women in Mali, about 94 percent of women aged 15 to 49 years had undergone genital cutting, which places them at higher risk for HIV transmission.

Significant seasonal migration of agricultural workers to Senegal, Côte d'Ivoire, and France during Mali's off-agricultural season could have a serious effect on the spread of HIV in Mali in coming years, particularly migration to and from Côte d'Ivoire, which has the highest HIV prevalence in West Africa.

Knowledge of AIDS in Mali is almost universal. According to the 1995–96 Demographic and Health Survey, 73 percent of women and 85 percent of men knew at least one way to prevent AIDS. Twenty-four percent of women and 45 percent of men mentioned the condom as an HIV prevention method, but only 6 percent of women and 24 percent of men said they had used a condom in the past two months.

Approximately 30 to 40 percent of infants born to HIV-positive mothers in Mali will also become infected with HIV, and most will die within two years. At the end of 1999, an estimated 45,000 children had been orphaned by the disease. Only six countries have a lower life expectancy than Mali. In addition to a current life expectancy of only 47 years, one out of every five children will die before age 5.

Adolescents are particularly vulnerable to HIV infection due to high-risk behaviors such as multiple sex partnering and drug and alcohol use. Young women, in particular, are vulnerable because of early sexual activity. By age 16, 50 percent of girls in Mali are either married or sexually active.

**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 100,000

**Total Population:** 11 million

**Adult HIV Prevalence:** 2.03%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 42.1%

Population at Low Risk: 2.5%

### USAID Strategy

To date, USAID/Mali-supported activities in HIV/AIDS have focused specifically on control and prevention of sexually transmitted infections as well as establishing a program for surveillance. Major activities address regional-level capability to support delivery of services for HIV and other sexually transmitted infections, including the development of technical skills to train service delivery providers in sexually transmitted infection case management, and Mali-specific sexually transmitted infection treatment approaches and counseling. Selected regional clinics are to be developed as model centers, allowing for the establishment of test programs for service delivery, health promotion, clinical services, laboratory services, training, surveillance, and operations research to help define optimal management strategies and evaluate promotion efforts. National-level sexually transmitted infection and HIV/AIDS diagnostic capability is also being developed at the National Institute for Public Health.

Expected results in the Mission's FY 2003–2012 strategic plan include the following:

- ⊙ Establishment of policies on HIV voluntary counseling and testing procedures (including pretest and posttest counseling protocols and rapid test procedures) and standards of care for persons living with HIV/AIDS;



- ⊙ Development of multisectoral approaches to mitigating the impact of HIV/AIDS;
- ⊙ Increasing the number of high-risk site services, support services for patients and families living with HIV/AIDS, and community support programs;
- ⊙ Increasing the supply of condoms and HIV/AIDS test kits;
- ⊙ Changing attitudes toward HIV/AIDS to enable discussion of the disease between partners and to decrease stigmatization;
- ⊙ Increasing knowledge of HIV/AIDS preventive practices, symptoms of sexually transmitted infections, and location of relevant services among high-risk groups and adolescents;
- ⊙ Establishment of education sector-specific HIV/AIDS strategies and interventions through the school system; and
- ⊙ Introduction of targeted radio broadcasts to increase demand for and facilitate access to HIV/AIDS products and services, and to promote social marketing of condoms.

#### **USAID-Supported Country Programs**

USAID supports the Centers for Disease Control and Prevention in its efforts to institutionalize the syndromic treatment of sexually transmitted infections in the public and private sectors. The Centers for Disease Control and Prevention provides ongoing long-term and short-term technical assistance in sexually transmitted infection control and institutional capacity strengthening to Programme National de Lutte contre le SIDA and other organizations in Mali. Specific collaborative activities include developing national sexually transmitted infection patient treatment policies; introducing laboratory procedures; training primary health care workers in the use of diagnostic algo-

rithms; assisting with a large, countrywide, integrated behavior and sexually transmitted infection prevalence surveillance study in collaboration with Programme National de Lutte contre le SIDA; and designing and implementing HIV voluntary counseling and testing and related services.

## **Mozambique**

Mozambique is one of nine African countries hit hardest by the HIV/AIDS epidemic. At the end of 2000, 1.47 million Mozambican adults were estimated to be living with HIV/AIDS, yielding an adult infection rate of 16 percent. Half of the persons living with HIV/AIDS are between the ages of 15 and 29. The number of cases is increasing, with the highest concentration in the center of the country and the most rapid incidence of new cases occurring in the southern region. Most infections are concentrated along transportation and commerce routes, disproportionately affecting mobile populations (i.e., miners, migrant workers, traders, drivers, and commercial sex workers) and their partners.

It is projected that by 2010, the AIDS crude death rate will increase in Mozambique by 98 percent from 1990. Rather than increasing to 50 years by 2010, life expectancy is expected to drop to 36 years. According to UNAIDS, approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected with HIV (at the end of 1999, an estimated 630,000 women were HIV-positive). In 1999, pediatric cases (children between the ages of 0 and 14) represented 23 percent of all AIDS cases in Mozambique. By 2015, infant mortality is expected to be at least 25 percent higher than what it would have been in the absence of

HIV/AIDS. By 2010, an estimated 1.13 million Mozambican children will have lost one or both parents to AIDS, contributing to economic, social, and political instability.

The social and economic isolation of the civil war somewhat protected Mozambique from the HIV epidemic brewing in neighboring countries. The end of the civil war, however, brought with it an increased vulnerability to HIV/AIDS fueled by the return of refugees from neighboring countries, the introduction of peace-keeping forces, and a marked increase in cross-border trade. Despite significant social and economic gains since the war's end, a convergence of conditions has contributed to the rapid spread of HIV/AIDS. They include widespread poverty, high levels of illiteracy, urban and cross-border migration, and the devastating losses from recent floods.

HIV/AIDS poses a strong threat to Mozambique's economic recovery. Projections indicate that the number of economically active persons in 2010 will not be 12.4 million as originally expected, but 10.8 million. The country's already fragile health care system is also threatened. Studies suggest that patients with AIDS may occupy up to 20 percent of rural hospital beds, and the cost of caring for people living with HIV/AIDS will overburden the country's inadequate health care system. Likewise, community-based care in Mozambique is particularly ill-prepared to care for people living with HIV/AIDS.

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**Estimated Number  
of Adults and Children  
Living with HIV/AIDS,  
end of 2000:**

1.47 million

**Total Population:** 16.9 million

**Adult HIV Prevalence:** 16%

**HIV-1 Seroprevalence  
in Urban Areas:**

Population at High Risk: 9%

Population at Low Risk: 9.9%

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**USAID Strategy**

USAID/Mozambique has developed a two-pronged strategy for HIV/AIDS prevention and care, based on the need to 1) increase knowledge, motivation, and skills for HIV risk reduction through behavior change communications and community-based skills training, and 2) increase the supply of HIV prevention services (i.e., condoms, voluntary counseling and testing, and sexually transmitted infection treatment) at the community level.

Components of the program include:

- ⊙ A nationwide condom social marketing program;
- ⊙ The integration of HIV/AIDS prevention and care activities into existing child survival and health activities in six provinces in the center of the country;
- ⊙ A comprehensive, aggressive, and intensive set of prevention and care activities in the Maputo Transportation Corridor, which will include an extensive media campaign, community mobilization activities, support to organizations of persons living with AIDS, and a workplace program, complemented by increased availability and quality of voluntary counseling and testing and sexually transmitted infection services;

- ⊙ Regional coordination along the Maputo Corridor to target high-risk groups that move between Mozambique and its neighbors, South Africa and Swaziland; and
- ⊙ Support to the Government of Mozambique's National AIDS Council to improve its ability to lead the nation's HIV/AIDS prevention efforts.

USAID is the lead donor in HIV/AIDS in Mozambique, and with resources available under the LIFE Initiative, USAID expects to contribute to the Government of Mozambique's efforts to slow the spread of the epidemic.

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## Namibia

With an adult HIV prevalence of more than 20 percent, Namibia is among the most HIV/AIDS-affected countries in Africa. At the end of 1999, an estimated 150,000 Namibians aged 15–49 were living with the disease; women accounted for 54 percent of these cases.

From 1990 to 2010, AIDS will increase the crude death rate in Namibia by more than 233 percent. As the number one cause of death for Namibians, AIDS will cause average life expectancy to drop to 38 years by 2010. The number of reported deaths due to HIV/AIDS in the 15- to 49-year age group continues to increase and now accounts for 47 percent of all deaths in hospitals.

HIV prevalence among pregnant women in Windhoek—a major urban area and the capital of Namibia—increased from 4 percent in 1991–1992 to 30 percent in 2000. In rural areas, median HIV prevalence among pregnant women was 15 percent in 1998. A 1998 study of patients with sexually

transmitted infections found a median 42 percent infection rate in urban areas and a 34 percent infection rate in rural areas. Preliminary data from the 2000 sentinel survey indicate that the epidemic is spreading and deepening. In the previously less affected southern regions of the country, rates have more than doubled since 1998, from 7 percent to 16 percent.

By 2010, infant mortality in Namibia is expected to be at least 63 percent higher than it would be without AIDS. Approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected with HIV. As of 1999, approximately 69,000 Namibian children had lost their mother or both parents to AIDS, according to Ministry of Health estimates.

The Namibian government in 1999 launched an expanded National AIDS Coordination Program. USAID began HIV/AIDS-specific programming in Namibia in 2000; the country is scheduled to graduate from U.S. assistance in 2005.

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**Estimated Number of  
Adults and Children  
Living with HIV/AIDS,  
end of 1999:**

160,000

**Total Population:** 1.7 million

**Adult HIV  
Prevalence:** 19.54%

**HIV-1 Seroprevalence  
in Urban Areas:**

Population at High Risk: 44.6%

Population at Low Risk: 22.7%

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**USAID Strategy**

USAID/Namibia's HIV/AIDS program has a multisectoral focus, incorporating private sector, local government, and youth activities. The program's special objective is to prevent and mitigate the impact

of HIV/AIDS in Namibia. This is achieved through building the capacity of public, private, and non-governmental sectors to provide a broad range of quality HIV/AIDS services. Strategies focus on:

- ⊙ Behavior change interventions,
- ⊙ Voluntary counseling and testing.
- ⊙ Care and support, and
- ⊙ Condom promotion.

### **USAID-Supported Country Programs**

The Mission has supported three local nongovernmental organizations in establishing HIV/AIDS programs and has worked to improve program credibility with the government and the international donor community. A USAID-supported partnership and referral program is active in the areas of voluntary counseling and testing, training, home-based care, advocacy, policy development, and legal assistance. Family Health International/IMPACT works with nongovernmental organizations to strengthen and expand capacity.

With the support of the Ministry of Basic Education, Sports and Culture, the Mission is also implementing a community-based orphans and vulnerable children education and care program.

The Mission will fund and provide technical assistance for impact analysis and the development of strategic plans in the education and local government sectors.

Legal assistance and advocacy will be supported through formulating and drafting policies and legislation to address discrimination in the workplace, providing legal advice and litigation services for people living with HIV/AIDS, engaging in advocacy on behalf of the HIV-infected, assisting nongovernmental organizations to develop advocacy skills, and training community paralegals.

## **Nigeria**

The HIV/AIDS epidemic in Nigeria has rapidly gained momentum and is now a major public health problem. Sentinel seroprevalence information has been available since the mid-1980s, however regular reporting did not begin until 1991–1992. The prevalence of infection has since increased from 1.8 percent in 1991 to 4.5 percent in 1996 and 5.4 percent in 1999. This prevalence, although lower than that of neighboring African countries, should be considered in the context of Nigeria's teeming population of approximately 109 million. The rise in prevalence represents an increase of more than 100 percent and in absolute terms implies that at least 2.7 million Nigerian adults and children were living with HIV/AIDS by the end of 1999. HIV prevalence among antenatal women in 1999 ranged from less than 1 percent to 21 percent. Among sex workers in Lagos, HIV prevalence rose from 2 percent in 1988–89 to 12 percent in 1990–91. By 1995–96, up to 70 percent of sex workers tested positive.

Current projections show an increase of in the number of new AIDS cases from 250,000 in 2000 to 360,000 by 2010. As a result of the epidemic, the crude death rate in Nigeria is expected to be 20 percent higher in 2000 than it was in 1990. Approximately 1.7 million Nigerian adults and children have died of AIDS since the beginning of the epidemic. In 1999 alone, 250,000 adults and children died of AIDS. At the end of 1999, approximately 971,472 children under the age of 15 lost a mother or both parents to AIDS.

Several factors contribute to the rapid spread of HIV in Nigeria. These include the widespread practice of polygamy and sexual networking, high prevalence of untreated sexually transmitted infections, low condom use, pover-

ty, low literacy, poor health status, low status of women, stigmatization, and denial of the HIV/AIDS epidemic. Data from UNAIDS show that Nigeria had an 18 percent prevalence rate for gonorrhea in 1994. Nigeria is a complex mixture of diverse ethnic groups, languages, cultures, religions, and regional political barriers, all of which are major challenges for HIV prevention programs.

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### **Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:**

2.7 million

**Total Population:** 109 million

**Adult HIV Prevalence:** 5.06%

### **HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 30.5%

Population at Low Risk: 6.7%

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### **USAID Strategy**

HIV/AIDS funding for Nigeria for fiscal year 2000 was \$8.75 million, including \$3.6 million under the Leadership and Investment in Fighting an Epidemic (LIFE) Initiative. This allocation marked a 200 percent increase over the FY 1999 \$2.7 million allocation, which included \$700,000 in supplemental funding for AIDS orphans. Prior to the election of the new civilian government in Nigeria, the entirety of USAID's HIV/AIDS assistance was given to nongovernmental organizations. In FY 1999, USAID began to examine ways to support the military HIV/AIDS program and the National Action Committee on AIDS. USAID's current HIV/AIDS program consists of 12 behavior change communication (preventative) activities, eight activities that focus on care and support of people living with HIV/AIDS, two activities that focus on care and support of children orphaned by HIV/AIDS, and one activity on AIDS



impact modeling and advocacy. USAID collaborates with the United Kingdom in supporting condom social marketing.

### **USAID-Supported Country Programs**

Family Health International/IMPACT is currently implementing a range of activities in Nigeria. Mass media/behavior change interventions include placing HIV/AIDS prevention messages on radio and billboards, and conducting music competitions with HIV prevention themes. IMPACT is also working to improve the quality and availability of sexually transmitted infection services through training of trainers, strengthen care and support programs for people living with HIV/AIDS, and support capacity building of non-governmental organizations.

In FY 2001, the Policy Project provided assistance to the National Action Committee on AIDS to develop a National Emergency Action Plan for HIV/AIDS. The Plan's objectives include:

- ⊙ Increasing awareness and sensitization of general population and key stakeholders;
- ⊙ Promoting behavior change in both low-risk and high-risk populations;
- ⊙ Ensuring that communities and individuals are empowered to design and initiate community-specific action plans;
- ⊙ Ensuring that laws and policies encourage the mitigation of HIV/AIDS;
- ⊙ Institutionalizing best practices in care and support for people living with HIV/AIDS;
- ⊙ Mitigating the effect of the disease on people living with HIV/AIDS, orphans and other affected groups;
- ⊙ Creating networks of people living with HIV/AIDS and others affected by AIDS;

- ⊙ Establishing an effective HIV/AIDS surveillance system; and
- ⊙ Stimulating research on HIV/AIDS.

## **Rwanda**

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), Rwanda is one of nine African countries most severely affected by the HIV/AIDS epidemic. As of 1999, more than 370,000 Rwandans—about 11 percent of the adult population—were living with the disease. AIDS is one of the three leading causes of death in Rwanda. By 2005, the crude death rate will be 40 percent higher due to AIDS than it was in 1990, and life expectancy will drop to 32 years by 2010.

In 1997, HIV prevalence levels in urban areas ranged from 10 to 28 percent among pregnant women. A 1996 study found infection rates ranging from 29 to 55 percent among men seeking care for sexually transmitted infections.

According to the Rwandan Ministry of Health, underlying causes of the AIDS epidemic include economic hardship and civil strife, high rates of multiple sex partnering, early onset of sexual activity, high rates of sexually transmitted infections, the availability of commercial sex, and resistance to talking about sex and using condoms.

Before the political turmoil of the mid-1990s, there had been more studies conducted on the HIV epidemic in Rwanda than in most developing countries. The infection pattern was a familiar one: high rates (more than 27 percent of pregnant women infected) in urban areas, but far lower rates (just over 1 percent) in rural areas, where most of the population lived. The civil war changed that pattern, and

by 1997 the urban-rural gap in HIV prevalence was closing.

Much of this shift can be ascribed to huge population movements during and after the years of ethnic conflict. Refugees who spent those years in countries with relatively strong HIV prevention programs had lower rates of infection than those who stayed in Rwanda. People who had lived in Rwandan refugee camps, however, endured overcrowding, violence, poverty, and despair—conditions that often led to rape or consensual but unprotected sex.

Rape—inside or outside refugee camps—has played a part in spreading the virus in Rwanda. Some 3.2 percent of women surveyed by UNAIDS after the war reported being raped. Of this group, 17 percent were HIV-positive, compared with 11 percent of women who had not been raped.

High rates of mother-to-child transmission have led the Rwandan government to counsel mothers against breastfeeding. By 2015, AIDS is expected to increase the country's already high infant mortality rate by 10 percent. At the end of 1999, 270,000 Rwandan children had been orphaned by AIDS.

Using 1997 figures, the Ministry of Health estimates that HIV prevalence among the sexually active population under age 20 is close to 10 percent. Four percent of Rwandans aged 12 to 14 years are already infected with HIV.

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<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>	<b>400,000</b>
<b>Total Population:</b>	<b>7.2 million</b>
<b>Adult HIV Prevalence:</b>	<b>11.21%</b>
<b>HIV-1 Seroprevalence in Urban Areas:</b>	
Population at High Risk	42.1%
Population at Low Risk:	19%

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## **USAID-Supported Country Programs**

### ***Behavior change***

USAID/Rwanda has successfully engaged several Protestant church networks in HIV/AIDS prevention programs, and has helped develop a series of HIV/AIDS messages and discussion guides for these churches. The Mission also supports the Family Health International/IMPACT project in its work with Ministry of Health medical teams to carry out behavior change programs in Kigali, Kibungo, Gitarama, and Byumba.

### ***Sexually transmitted infection management***

Family Health International/IMPACT works with the National Reference Laboratory and other donors to promote aggressive screening and treatment of sexually transmitted infections, particularly among high-risk groups. Together with the Ministry of Health, Family Health International also trains health care workers in sexually transmitted infection management.

### ***Voluntary counseling and testing***

USAID/Rwanda has supported development/adaptation of simple protocols and standards for voluntary counseling and testing activities in Rwanda, including a standardized curriculum for counselor training. Family Health International/IMPACT established several new voluntary counseling and testing centers in FY 2000, and worked to improve counseling and testing services at existing voluntary counseling and testing centers. The project provides training for counselors and laboratory technicians and ensures technical quality control supervision at voluntary counseling and testing sites.

### ***Prevention of mother-to-child transmission***

USAID has worked with UNICEF and the Centers for Disease Control and Prevention to finalize

protocols for expanding mother-to-child transmission services throughout Rwanda. The Mission also provides ancillary outreach and community support activities to create a holistic program of prevention and treatment at mother-to-child transmission centers.

### ***Care and support***

The Mission supports local non-governmental organizations in developing activities to support people living with HIV/AIDS, including income-generating activities and counseling. In FY 2000, the Mission supported a regional conference on people living with HIV/AIDS to stimulate discussion on appropriate and effective care and support interventions. The Mission also provides food aid to children affected by HIV/AIDS through the Leadership and Investment in Fighting an Epidemic initiative.

USAID has awarded grants to CARE International and World Relief to support the Rwandan Ministry of Health and Ministry of Social Affairs in protecting children made vulnerable by HIV/AIDS. Programs provide training in appropriate care and counseling to caregivers of unaccompanied children and to some of the 85,000 child-headed households in Rwanda. Another USAID grant to the International Rescue Committee supports policy and technical guidance to the Ministry of Social Affairs to protect the rights and well-being of children affected by HIV/AIDS.

### ***Capacity building***

In FY2000, USAID/Rwanda provided direct support to the National AIDS Control Program and the Ministry of Health to strengthen capacity to provide technical and policy guidance on HIV/AIDS activities throughout Rwanda. The Mission also supported several major studies to provide essential information on sexual

behavior and perceived personal risk for HIV, including the Demographic and Health Survey, the Behavioral Surveillance Survey, and a situation analysis of health facilities in target zones for HIV/AIDS interventions.

## **Senegal**

Senegal is often presented as a developing world success story in HIV prevention. The country has maintained one of the lowest HIV prevalence levels in sub-Saharan Africa, where it has risen only slightly from 1.2 percent in the adult population in 1995 to 1.77 percent at the end of 1999. An estimated 76,000 Senegalese adults and 3,300 children were living with HIV/AIDS at the end of 1999. This comparatively low level in relation to other African countries is due to a combination of early and comprehensive strategic approaches to controlling the epidemic, coupled with continued commitment from Senegalese authorities.

A meta-analysis conducted by UNAIDS in 1997 and again in 2000 attributed the low prevalence of HIV/AIDS among the general population to the following factors:

### ***Conservative cultural norms regarding sex.***

Premarital sex is relatively less common in Senegal than in other countries in the region. For women in urban areas, the probability of first sexual encounter before the age of 20 years is 20 percent compared with 30 percent or 40 percent in neighboring countries.

### ***Creation of safe blood supply for transfusion.***

The national blood supply system, which has systematically tested for syphilis and hepatitis since the 1970s, was reinforced in 1987 to

prevent the transmission of HIV through blood transfusion. National and regional blood banks have appropriate equipment and personnel trained for HIV testing in the country's 10 regions.

***Registration and regular medical checkup of commercial sex workers.***

Since 1969, registered commercial sex workers have been required to undergo an annual health checkup and receive treatment for curable sexually transmitted infections. This system of registration has provided a framework to approach this target group with educational and health campaigns.

***Promotion of condom use.***

Condom promotion is a major component of the National AIDS Control Program strategy. Condoms are distributed free of charge to commercial sex workers, patients with sexually transmitted infections, peer educators, and people who attend AIDS-related event days. In addition, condom social marketing through a fee-based public and private sector distribution network complements the free condoms available in service delivery sites throughout the country.

***Information, education, and communication and behavior change communication interventions.***

Comprehensive information, education, and communication, and behavior change communication programs through nongovernmental organizations and community-based organizations have targeted specific groups such as commercial sex workers, youth, low-income women, truck drivers, and spouses of migrant workers. In addition to mass media campaigns and massive production of information, education, and communication materials, significant efforts have been made to reach youth and women through special events such as World AIDS Day, Youth Week Against AIDS, and Women's Week Against AIDS.

***Active involvement of community, political, and religious leaders.***

Senegal is fortunate to have thousands of experienced associations, movements, and community organizations working in the health field. These groups have served as highly effective conduits for community and social mobilization for preventive AIDS messages. As early as 1989, the government collaborated with religious organizations to discuss its AIDS prevention strategy. In 1995 a national conference of senior religious leaders resulted in their active support for HIV prevention. The religious leaders themselves have called for a partnership between Christian and Muslim leaders to join forces in the fight against AIDS.

***Strengthening the management of sexually transmitted infections using a syndromic approach.***

A syndromic approach to sexually transmitted infection treatment has contributed to improving service quality and increasing awareness about sexually transmitted infections among the general population. Major activities have included a district-level needs assessment and ethnographic studies, training and intensive supervision of health personnel, and continuous evaluation of the quality of sexually transmitted infection management services at the health district level.

***Monitoring seroprevalence on a continuous basis.***

Sentinel surveillance of HIV started in 1987 and provides useful and regular information on the evolution of the epidemic.

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**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 79,000

**Total Population:** 9.2 million

**Adult HIV Prevalence:** 1.77%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 6.1%

Population at Low Risk: 4%

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***USAID Strategy***

USAID supports interventions at the following levels:

National. USAID provides training and supervision in application of service delivery norms and protocols—medical, outreach, information, education, and communications/behavior change communication, logistics—throughout the country.

Central. USAID supports policy dialogue, research, monitoring and evaluation, and information dissemination and communication.

District/Community. USAID supports local health services and systems support including development, implementation, and monitoring and evaluation of local health action plans.

***USAID-Supported Country Programs***

***Behavior change communication***

Initiatives target high-risk groups, particularly mobile populations, and encourage behavior change through multiple communication channels. Community-based organizations and local nongovernmental organizations are supported to develop outreach activities to reach these groups.

***Reaching in-school youth***

USAID carries out a two-pronged approach aimed at primary, secondary, literacy, and technical/vocational school students to



- 1) establish a positive environment for HIV/AIDS prevention among educational personnel, and
- 2) encourage positive behavior for HIV/AIDS prevention among targeted youth groups through innovative channeling of messages

### ***Voluntary counseling and testing***

Until recently, testing for HIV/AIDS had been conducted only at certain hospitals and required a doctor's referral. USAID plans to increase access to high-quality voluntary and anonymous counseling and testing services, establish a quality assurance mechanism for testing sites, and establish an effective and broad-based network linking testing facilities to basic care and support services for persons with HIV/AIDS.

### ***Condom promotion***

Since 1985, USAID has provided the National AIDS Control Program with more than 10 million condoms for distribution to commercial sex workers, patients with sexually transmitted infections, youth, and adults through clinics and during AIDS-related event days. In addition, since 1995, USAID has promoted social marketing efforts with a local non-governmental organization that works through pharmacies and non-traditional outlets.

### ***Care and support***

Linking prevention and care has been found to be an effective means to reinforce community responses to HIV and increase the involvement of people living with HIV/AIDS. The linkage between these services and community participation for care is an essential component of the USAID strategy as are increased access to care for people living with HIV/AIDS and increased involvement of people living with HIV/AIDS in prevention activities.

USAID will assist the National AIDS Program to assess the care

and support situation in Senegal and design a national strategy for decentralization of the care continuum. In addition, it will reinforce the nutritional unit of the center for ambulatory care for people living with HIV/AIDS. Finally, USAID and its partners will reinforce the existing network of people living with HIV/AIDS at the community level, identify partnerships that need to be developed, geographically expand the model support network for people living with HIV/AIDS developed by USAID's community mobilization partner, and link them to voluntary counseling and testing services.

### ***Capacity development***

Since the onset of the epidemic, a continuing process of information, sensitization, and advocacy aimed at community, religious, and political leaders has resulted in the establishment of a constructive dialogue on HIV/AIDS issues based on social, cultural, and religious realities in Senegal. This has led to the creation of a multidisciplinary group of advocates for HIV prevention interventions. Specific objectives of the USAID program include the enhancement of political support to HIV/AIDS prevention at high levels and the reinforcement of a policy dialogue at the highest level within neighboring countries.

Activities in the workplace consist of operations research to integrate microcredit activities with HIV prevention targeting fishermen and transporters, and publication of an information bulletin for widespread distribution among business leaders, ministries, and unions. USAID will also focus on building a sustainable partnership with various media outlets and enhancing their role in increasing public awareness and supporting advocacy for HIV/AIDS prevention.

Finally, USAID will support a sub-regional meeting involving decision-makers and opinion leaders

from neighboring countries to build linkages between organizations implementing HIV prevention activities and promote development of a favorable environment for HIV/AIDS prevention at the regional level.

### ***Monitoring and evaluation***

USAID plans to help the National AIDS Program build its capacity and infrastructure to more effectively monitor and evaluate both the evolution of the epidemic and the effectiveness of various interventions. There is an urgent need to reorient the surveillance system to target areas with high international migration, include other high-risk groups such as truckers and fishermen, and collect behavioral information as a means for informing trends in HIV/AIDS across the country. Specific objectives of the program aim to develop and implement a second generation surveillance system and establish a laboratory quality assurance and control program at both the national and local levels.

## **South Africa**

With a 20 percent HIV infection rate among adults and an estimated 4.2 million adults and children living with HIV/AIDS, South Africa is among the worst-affected countries in the world. The nation is home to half of all HIV-positive people in the nine southern African countries hardest hit by the pandemic, and it recently surpassed India as the nation with the greatest number of people living with HIV/AIDS.

Every day in South Africa, an estimated 1,700 people acquire new HIV infections. Young adults aged 20–24 are the most affected age cohort, with a prevalence of 25.6 percent. The government estimated in March 2000 that 24.5 percent

of pregnant women attending public antenatal clinics in 1999 carried HIV, up from 22.4 percent in 1998.

By 2010, adult HIV prevalence is projected to reach 25 percent. In 2005, the population is expected to be 16 percent smaller than it would have been in the absence of AIDS. By 2015, population loss to AIDS-related deaths will be 4.4 million people.

The migrant labor system in the trucking and mining sectors is fueling the HIV/AIDS pandemic in South Africa. A survey in Carltonville, a gold mining area near Johannesburg, revealed that 60 percent of the 88,000 miners had come from other parts of South Africa or from the neighboring countries of Lesotho, Malawi, and Mozambique. One-fifth of miners were HIV-positive, and 75 percent of the 400 to 500 sex workers who serviced the miners were HIV-positive.

In 1994, men with sexually transmitted infections attending Johannesburg clinics were found to have an HIV rate of close to 19 percent. HIV prevalence among pregnant women in urban areas increased from 1 percent in 1990 to 19 percent in 1998, and infection rates among sex workers in KwaZulu/Natal Province increased from 50 percent in 1997 to 61 percent in 1998.

About half of South Africa's population is under age 15. AIDS will increase the infant mortality rate in the next five years by 26 percent. In Soweto township's Baragwanath Hospital, the largest in the southern hemisphere, one-third of children under age 5 admitted each year carry the virus. As of 1999, 420,000 South African children had been orphaned by AIDS.

By 2010, life expectancy in South Africa is estimated to be about 45 years with AIDS, as compared to close to 70 years without AIDS,

according to the United Nations Development Programme.

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**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 4.2 million

**Total Population:** 39.8 million

**Adult HIV Prevalence:** 19.94%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 50.3%

Population at Low Risk: 32.5%

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### *USAID Strategy*

USAID forms part of the Health Working Group of the Binational Commission. USAID/South Africa's strategic objective in health supports increased use of essential primary health care and HIV/AIDS prevention and mitigation services and practices. The Mission's response to the HIV/AIDS epidemic includes:

- ⊙ Increasing access to prevention services,
- ⊙ Increasing demand for prevention and mitigation services and practices,
- ⊙ Improving the quality of services and practices,
- ⊙ Expanding the use of better practices outside initial pilot area activities, and
- ⊙ Expanding the multisectoral response for prevention and mitigation of HIV/AIDS.

### *USAID-Supported Country Programs*

With USAID funding, the Centers for Disease Control and Prevention has, since 1992, provided technical assistance in epidemiology and surveillance, institutional and capacity building, sexually transmitted infection prevention and control, HIV/AIDS counseling

and testing, partner notification and referral, and policy development. Other USAID-supported agencies working in HIV/AIDS prevention and mitigation include Family Health International/IMPACT, Population Services International/AIDSMark, The Futures Group, John Snow Inc., EngenderHealth, the Center for Human Services, and the Population Council/Horizons Program.

Mission initiatives in HIV/AIDS have focused on training, advocacy, community outreach, and institutional capacity building, with the following results:

- ⊙ Nongovernmental organizations have made a substantial contribution to community outreach and HIV/AIDS awareness activities in rural and informal settlement areas.
- ⊙ A nationwide demographic and health survey was conducted in 1998.
- ⊙ An improved referral system reduced hospitals' outpatient loads.
- ⊙ A national AIDS strategy was developed at a USAID-supported national AIDS convention.
- ⊙ The Department of Health, in collaboration with The Futures Group, held training workshops to build skills in advocating for leadership support for strong multisectoral HIV/AIDS programs at both national and provincial levels.
- ⊙ An in-service management training program was developed for health managers at the provincial level and below.
- ⊙ A legal charter to prevent discrimination against persons living with HIV/AIDS was developed.
- ⊙ The Department of Public Service and Administration, the largest employer in South

Africa, is developing an HIV/AIDS workplace policy.

- ⊙ A strategy to assist orphans and vulnerable children has been developed.
- ⊙ The Nelson Mandela Children's Fund received a grant to expand prevention, care, and support to vulnerable communities.
- ⊙ The Department of Health, in collaboration with John Snow Inc., is improving the logistical support system for procurement and distribution of condoms and other supplies and commodities.
- ⊙ Research on voluntary counseling and testing, mother-to-child transmission, therapeutic interventions, and behavioral interventions is being conducted and expanded through community-based programs through a cooperative agreement with the Perinatal HIV/AIDS Research Unit at Baragwanath Hospital.
- ⊙ The Department of Health, in collaboration with the Reproductive Health Research Unit at the University of Witwatersrand, has embarked on two national initiatives, the National Adolescent Friendly Clinic Initiative and the National STI Initiative.

## Tanzania

Since the first three AIDS cases were reported in Tanzania in 1983, the epidemic has increased at an alarming pace. HIV infection is being driven by high-risk heterosexual behavior, compounded by high levels of sexually transmitted infections. According to UNAIDS, approximately 8 percent of adults (age 15 and over), or 1.3 million Tanzanians, were living with HIV/AIDS as of late 1999.

From 1990 to 2010, AIDS will increase the crude death rate in Tanzania by more than half. By 2010, life expectancy will drop from 65 years to about 37 years due to HIV/AIDS.

HIV prevalence among pregnant women nationwide jumped from 4 percent in 1986 to as high as 44 percent in some sentinel sites in 1999. In Dar es Salaam, 50 percent of sex workers tested HIV-positive in 1993. Twenty-four percent of patients with sexually transmitted infections in Dar es Salaam and 27 percent of patients outside of the city tested positive in 1997.

According to the 1999 Tanzania Reproductive and Child Health Survey, close to 100 percent of Tanzanian adults had heard of AIDS—an increase from 76 percent in 1996. Eighty percent of women know at least one of three methods of protecting themselves from HIV, and almost half knew all three methods. More than 70 percent of men and 56 percent of women knew that condoms provide protection from HIV. Although knowledge about HIV prevention has increased markedly in the last several years, condom use remains very low in Tanzania. Only 16 percent of women and 37 percent of men had ever used a condom, mostly for family planning purposes.

According to UNAIDS, 50,000 to 60,000 Tanzanian children are born HIV-positive every year. By 2015, the already high infant mortality rate is expected to be at least 16 percent higher than it would have been without AIDS. An estimated 1.1 million children had been orphaned by AIDS as of 1999.

Young adults aged 15 to 24 account for 60 percent of new HIV infections in Tanzania, while comprising only 20 percent of the population. By age 15, 20 percent of women have had sex and by age 18, 68 percent have had sex. Epidemiological data and qualitative studies show

that young women are at great risk for infection for both biological and social reasons.

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**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 1.3 million

**Total Population:** 32.8 million

**Adult HIV Prevalence:** 8.09%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 24.4%

Population at Low Risk: 13.7%

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### USAID Strategy

USAID/Tanzania works with both the public and private sectors to implement its HIV/AIDS activities. The Mission has supported the development of networks of indigenous nongovernmental organizations that address HIV/AIDS, dissemination of HIV/AIDS behavior change communication information through various media outlets, social marketing of male and female condoms, and strengthening Tanzanian leadership for development of national HIV/AIDS and health care programs. Activities have also included training for syndromic diagnosis and treatment of sexually transmitted infections, extensive peer education, workplace programs, and care and support for persons living with HIV/AIDS.

The Mission also supports capacity building within government and advocates for appropriate responses to HIV/AIDS at the national and district levels. USAID is the lead donor in the Development Assistance Committee donor forum on HIV/AIDS issues and played a critical role in establishing a multi-sectoral, high-level Tanzania AIDS Commission, announced by the President of Tanzania in December 2000.



USAID/Tanzania supports activities to:

- ⊙ Address weak policy and legal environments surrounding HIV/AIDS and strengthen national leadership;
- ⊙ Develop behavior change communication messages to decrease stigma and encourage individual and institutional behavior change;
- ⊙ Provide male and female condoms through social marketing campaigns;
- ⊙ Support strengthening of civil society organizations to advocate for improved policy and action as well as provide services;
- ⊙ Develop and strengthen HIV/AIDS policies and prevention and care programs in the workplace;
- ⊙ Train nongovernmental organizations to provide indigenous, community-based approaches to AIDS prevention, education, counseling, and testing; and
- ⊙ Build district-level public/private partnerships to address HIV/AIDS, as well as reproductive and child health concerns.

## Uganda

Innovative and rigorous approaches to HIV prevention and care, and an environment of strong political will and leadership created by President Yoweri Museveni have established Uganda as a model for curbing the epidemic in the developing world. With the help of international and indigenous nongovernmental organizations, including strong support from faith-based and community-based groups, Uganda successfully reduced its HIV prevalence rate by over 50% from 1992 to 1999.

HIV prevalence in Uganda has significantly declined throughout the past decade. At the end of 1999, prevalence among the adult population was estimated to be 8.3 percent.

Declines in HIV prevalence have been demonstrated among several populations. For example:

- ⊙ Urban populations: HIV prevalence declined in Kampala from 31 percent in 1990 to 14 percent in 1998;
- ⊙ Rural populations: Median HIV prevalence declined from 13 percent in 1992 to 8 percent in 1998; and
- ⊙ Women: In 1989, 62 percent of patients with sexually transmitted infections who tested positive for HIV declined from 62 percent in 1989 to 37 percent in 1997. Prevalence has also declined among pregnant women in selected antenatal sentinel surveillance sites.

The impact of HIV/AIDS continues to weigh heavily on Uganda, however. At the end of 1999, an estimated 820,000 Ugandans were living with HIV/AIDS, and 1.7 million children had lost their mother or both parents to the disease since the beginning of the epidemic. Approximately 1 million of these children are currently living. Eighty to 90 percent of new HIV infections are estimated to be due to unprotected heterosexual contact. The highest prevalence can be found among 20- to 39-year-olds. HIV/AIDS-related illnesses are the leading cause of mortality in adults 15 to 49 years old. According to data from Johns Hopkins University, 10 to 12 percent of the 1 million pregnant women who deliver in Uganda per year are estimated to be HIV-infected, accounting for the birth of 30,000 to 36,000 HIV-infected children every year.

In 2000, life expectancy was estimated to have declined by more than 20 percent—from 54 to 43

years of age since the beginning of the epidemic. The crude death rate was expected to be 50 percent higher than without AIDS. The infant mortality rate was expected to be approximately 11 percent higher than it would be in the absence of AIDS. The child mortality rate (for children under age 5) was 163 per 1,000, compared with 133 without AIDS—a 23 percent increase, according to the U.S. Census Bureau.

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### Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:

820,000

**Total Population:** 21.1 million

### Adult HIV

**Prevalence:** 8.3%

### HIV-1 Seroprevalence in Urban Areas:

Population at High Risk: 29.4%

Population at Low Risk: 13.8%

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### USAID Strategy

USAID/Uganda's strategy is primarily to collaborate with and support governmental and nongovernmental organizations working under the national strategic, multisectoral HIV/AIDS framework. USAID/Uganda works closely with other U.S. government agencies (i.e., the Centers for Disease Control and Prevention and the Department of Defense) to ensure a comprehensive approach with complementary activities.

USAID-funded activities focus on: 1) increasing availability and accessibility; 2) increasing capacity; and 3) creating a supportive environment for HIV/AIDS prevention, care and support programs. Specific activities include HIV voluntary counseling and testing, HIV/AIDS care and support programs (counseling, treatment of opportunistic infections and sexually transmitted infections, psychoso-

cial support, income generating activities), programs for orphans and vulnerable children (development of a national policy, peer education, training and income-generating activities, support to care-givers, school fees, counseling), social marketing of condoms, and integrated health care delivery including HIV/AIDS. USAID also provides key technical and program support for national initiatives such as prevention of mother-to-child transmission, monitoring and evaluation, surveillance, tracking and monitoring of national HIV/AIDS initiatives, prevention and behavioral change communication efforts focusing on youth (in and out of school), couples, and other special populations.

#### **USAID-Supported Country Programs**

Innovative projects USAID has supported include:

- ⊙ A five-year (2001–2006) \$20 million cooperative agreement, funded in collaboration with the Centers for Disease Control and Prevention, was recently awarded to the John Snow Inc. Research and Training Institute to develop comprehensive, integrated HIV/AIDS services in 10 districts throughout Uganda.
- ⊙ A six-year, \$30 million activity, which uses U.S. Department of Agriculture P.L. 480 Title II food commodities to help meet the nutritional needs of families and orphans affected by the HIV/AIDS epidemic. The program is the largest of its kind in the world. The target population is an estimated 60,000 individuals infected with HIV/AIDS, or living in households where food security has been undermined by HIV/AIDS.
- ⊙ The AIDS Information Center, the first program in Africa to offer voluntary counseling and testing for HIV, since 1990.
- ⊙ The AIDS Support Organization, the first and largest indigenous HIV/AIDS care and support organization in Africa, from 1988 to present.
- ⊙ The first “AIDS in the Workplace” project in Africa.
- ⊙ One of the first “AIDS in the Military” projects.

## **Zambia**

While Zambia has a lower national HIV prevalence than many countries in Southern Africa, its current prevalence rate of 19.7 percent remains very high and calls for urgent expanded interventions focusing on behavioral change and a broad package of care and support services to mitigate the widespread impact of the epidemic. National surveillance activities were last reported by the Ministry of Health in 1998. A new surveillance round began August 2001. Results will be disseminated in 2002.

Recent analysis of age-specific prevalence levels show encouraging trends among 15- to 19-year-olds and 20- to 25-year-olds. Between 1993 and 1998, there was a 42 percent decline in HIV seroprevalence among Zambian youth 15 to 19 years old. Seropositivity rates dropped from 28 percent in 1993 to 15 percent in 1998 for the 15- to 19-year-old group in Lusaka. Data were validated by an independent team from UNAIDS. National behavioral surveillance data indicate a reduction in reported casual sexual behavior from 17 percent in 1996 to 11 percent in 1999. There has been a marked increase in condom use, particularly for sexual relations between casual partners.

In urban areas, there has been an increase in condom use among all age groups from 36 percent in 1996 to 48 percent in 1999. In 2000, condom sales through social marketing rose to 8.6 million.

Zambia has national surveillance data from a number of population-based surveys. A recent peer-reviewed publication (2001) also documented this trend and attributed declining seroprevalence to behavioral change through delay in the onset of sexual activity, abstinence among youth, and more consistent condom use among youth.

The impact of the epidemic is being felt at all levels of society and in every sector. The impact is particularly strong on Zambian families and patterns of traditional socialization. There is a continuing increase in the numbers of orphans (currently estimated at 650,000 due to the AIDS epidemic). Youth-headed households are reported in many Zambian urban and rural districts.

#### **Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:**

**870,000**

**Total Population:** 9.7 million

**Adult HIV Prevalence:** 19.7%

#### **HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 68.7%

Population at Low Risk: 27.1%

#### **USAID Strategy**

USAID/Zambia supports a multi-sectoral approach to HIV/AIDS. The goal of its program is to mitigate the impact of HIV/AIDS on people, institutions, and development in Zambia through partnerships with communities, the government, nongovernmental organizations, and the private sector. HIV/AIDS is included in each of the Mission's four strategic objectives: agriculture and the private sector; education; population, health, and nutrition; and democracy and governance. The three main components of the USAID/Zambia Multisectoral HIV/AIDS Program are prevention, care and

support, and mitigating the impact of HIV/AIDS on each sector.

### **USAID-Supported Country Programs**

Zambia is one of four USAID-designated “rapid scale-up” countries and is funded at \$13 million for HIV/AIDS activities in FY 2001. USAID is the lead donor in HIV/AIDS in Zambia. USAID/Zambia is supporting the Zambia Integrated Health Program, a five-year program that includes integration of HIV/AIDS activities. Key interventions are behavior change communications, increasing access to condoms, control of sexually transmitted infections, voluntary counseling and testing, community care and support services, and policy development.

USAID-supported voluntary counseling and testing services are currently being initiated in four districts as part of a multidonor program called the Zambia Voluntary Counseling and Testing Partnership, which operates 30 voluntary counseling and testing sites nationwide. Services offered under the partnership include community mobilization, program assessment, voluntary counseling and testing promotion, clinic renovation, and care and support activities, including “positive living” courses.

A demonstration project for pregnant women in Ndola District provides voluntary counseling and testing services at six sites, with the goal of reducing mother-to-child transmission of HIV. For the first year, 1,280 persons were tested for HIV at these sites, with an overall prevalence of 35.5 percent.

A USAID-supported youth mass media campaign, Helping Each Other to Act Responsibly Together (HEART), stresses abstinence for youth who are not sexually active and condom use for those who are. The campaign has produced five television advertisements and an award-winning music video titled

“Abstinence is Cool.” About 70 percent of urban youth and 37 percent of rural youth report seeing at least one of the campaign’s ads. In the project’s second phase, 22 radio spots in seven languages were produced to target rural youth.

Zambia now has the most comprehensive cross-border initiative in Africa. Through a strategic partnership between USAID (regional and bilateral) and the Japan International Cooperation Agency, this initiative targeting high-risk populations has expanded to six sites in 2001. The intervention targets sex workers and commercial truck drivers through condom social marketing, peer education, and treatment of sexually transmitted infections.

Family Health International/IMPACT, World Vision, and the Society for Family Health are implementing an HIV/AIDS prevention and control program targeting truck drivers and sex workers at six border sites. By February of 2001, 499 commercial sex workers had been treated and a total of 996 were seen for consultations. The program is being scaled up to include multisectoral activities aimed at youth.

Zambia’s SCOPE/orphans and vulnerable children program, implemented by CARE International, Family Health Trust, and Family Health International/IMPACT, works to mobilize community resources to care for orphans and vulnerable children. The project—active in seven districts—provides assistance in creating economic safety nets and providing psychosocial support to children and families hardest hit by the epidemic. USAID also supports a national multisectoral structure to address orphans and vulnerable children program policy and coordination.

An HIV/AIDS workplace initiative, FACEAIDS, was initiated in FY 2000 through the Zambia

Integrated Health Program. As of spring 2001, it had provided information, education, and communication materials at six work sites in Lusaka and in Zambia’s Copperbelt, reaching 454 employees.

USAID has supported a strong social marketing program for condoms since 1991. Sales continue to increase significantly for the second straight year: more than 30 percent over the previous year—from 6.6 million to 8.6 million. Sales of female condoms reached 73,500 in 2000—double the target set for that year.

USAID supports national and district-level training on the AIDS Impact Model presentation module. USAID supports creation of information, education, and communications materials on HIV/AIDS for schools; long-distance education programs for orphans and vulnerable children; and creation of Anti-AIDS clubs in Zambian schools.

In the agricultural sector, HIV/AIDS messages were printed on 800,000 fertilizer sacks, reaching an estimated 100,000 farmers. HIV/AIDS awareness messages were included in the post-harvest survey, reaching more than 8,000 rural households, and HIV/AIDS training of farmers took place in four cooperative farming districts.

USAID supported a media campaign on HIV, human rights, and workplace issues through the Policy Project and worked with the Zambia Counseling Council to increase the number of HIV/AIDS counselors for voluntary counseling and testing services. The Mission also worked with the Network of Persons Living with HIV/AIDS on institutional strengthening, including instituting monthly debates on critical issues of HIV/AIDS.

Also during FY 2000, USAID helped build the capacity of 14 nongovernmental organizations working in HIV/AIDS prevention



and mitigation. Activities included developing best practices in programming, holding strategic planning workshops, and offering instruction in budget and proposal development.

USAID was a key player in establishing the National HIV/AIDS Secretariat and Council in March 2000, and provided technical assistance to develop the *Zambian National HIV/AIDS Strategic Framework*, which was finalized later that year.

Recent operations research supported by USAID include a sexually transmitted infection study in three mining communities and a voluntary counseling and testing/maternal and child health demonstration project in Ndola. Additional research is assessing the involvement of persons living with HIV/AIDS in community-based preventive and care and services.

Finally, USAID continues to work with the Zambia Interfaith Network to build HIV/AIDS-related leadership and advocacy skills among pastors and congregational leaders in faith-based organizations.

## Zimbabwe

With an adult HIV prevalence rate of 25 percent, Zimbabwe is among the countries hardest hit by HIV/AIDS in sub-Saharan Africa. At the end of 1999, 1.4 million adults were living with the disease, and approximately 2,000 people were acquiring HIV infections every week. As a result of HIV/AIDS, the crude death rate in Zimbabwe will be more than 200 percent higher in 2005 than it was in 1990.

Zimbabwean life expectancy is predicted to decline to 35 years by 2010, compared with 66 years in 1997. The population is expected

to stop growing because of HIV/AIDS, and by 2015, it will be 19 percent smaller than it is today.

In 1997, a median of 30 percent of pregnant women attending clinics nationwide tested positive for HIV. In 1994–95, 86 percent of sex workers in Harare were HIV-positive, and in 1995, 71 percent of patients with sexually transmitted infections tested positive for HIV.

The number of AIDS cases among women peaks in the 20- to 29-year-old range, the prime reproductive and parenting years. Mortality rates for men and women are approximately equal until age 30, after which mortality of men exceeds that of women by 26 percent.

Children under age 5 account for 15 percent of new AIDS cases. The Zimbabwean government is conducting pilot studies on the effectiveness of antiretroviral treatment in reducing mother-to-child transmission. By 1999, an estimated 900,000 children in Zimbabwe had lost their mother or both parents to AIDS.

In the 15- to 19-year-old age group, more than five times as many young women as young men are reported to be HIV-positive. The age and gender distribution of AIDS cases in Zimbabwe shows that much of the HIV transmission occurs from older men to younger women.

Zimbabwe was the first country in Africa to introduce the female condom. It was approved for wide use after a petition was drafted by women's advocacy groups, signed by about 20,000 individuals, and presented to the Ministry of Health. The female condom is now available through both social marketing programs and in public clinics.

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<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>	1.5 million
<b>Total Population:</b>	11.5 million
<b>Adult HIV Prevalence:</b>	25.06%
<b>HIV-1 Seroprevalence in Urban Areas:</b>	
Population at High Risk:	86%
Population at Low Risk:	28%

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### USAID Strategy

Since 1994, USAID/Zimbabwe's HIV/AIDS strategy has focused on encouraging responsible behavior change. The strategy consisted of a comprehensive range of communications activities that targeted high-risk populations on commercial farms, in the transport industry, in the military and in the private sector. Mass media campaigns targeted the general population, while youth were targeted via an HIV/AIDS education course that was added to the school curriculum. Over the last few years, this strategy contributed to near-universal awareness: Most studies show that at least 98 percent of the general population is aware of HIV/AIDS. However, this approach met with limited success because high awareness did not lead to behavior change.

In 1997, the Mission made a strategic shift in view of its results to date. After a careful analysis of best practices in HIV/AIDS prevention in other African contexts, the Mission refocused its efforts. A voluntary HIV counseling and testing initiative is now the centerpiece of a portfolio that includes several complementary activities designed to promote responsible behavior change.

## USAID's Family Health and AIDS Program in West and Central Africa: Burkina Faso, Cameroon, Côte d'Ivoire, Togo

While the HIV/AIDS epidemic in West and Central Africa has long been categorized as less severe than in other parts of Africa, it is increasingly affecting life in West African nations. Cultural and societal norms have contributed to the slower spread of the disease, as well as the fact that HIV-2, which is less transmissible than HIV-1, is more prevalent in West Africa than in Eastern and Southern Africa.

In 1999, UNAIDS estimated HIV infection rates of 5 percent in Burkina Faso, almost 8 percent in Cameroon, 11 percent in Côte d'Ivoire, and 6 percent in Togo. While these prevalences are in themselves alarming, they mask higher levels of prevalence found in high-risk groups and in certain geographic areas.

The impact of rising prevalence in the four countries covered by USAID's Family Health and AIDS program in West and Central Africa is rapidly becoming apparent. For example, it has been projected that monthly per capita income among families living with AIDS in Côte d'Ivoire is only 32 percent of that of families not affected by AIDS. In addition, at current and projected prevalences, the life expectancy of a child born in Côte d'Ivoire in 2000 is estimated at 46 years, as opposed to 58 years if AIDS were not present in the population.

### *USAID Strategy*

Historically, the Family Health and AIDS program has provided technical assistance and guidance in health care and HIV/AIDS in the four countries in which USAID formerly supported bilateral programs. In 2000, USAID approved its regional strategy for development in West Africa—the West Africa Regional Program—and the Family Health and AIDS program became the Agency's primary health project in the region. Operating under West Africa Regional Program, the program, while continuing to support key initiatives in the four focus countries, will provide select strategic support throughout 17 African countries. This support will be provided through several approaches, including regional meetings, sharing effective tools, and approaches, and providing technical assistance at the country level.

In FY 2001, USAID developed a strategic vision for regional HIV/AIDS intervention in West and Central Africa. Key elements of this strategy are outlined below.

### *USAID-Supported Country Programs*

#### *Behavior change communication*

Since 1995, a variety of communication strategies, including mass media campaigns implemented through song, and television and radio dramas, have been used to reach high-risk populations as well as the general population. The USAID regional program works to strengthen prevention efforts through counseling at government and nongovernmental clinics supported by the broader USAID health initiative and, in particular, plans to increase efforts in dual protection promotion (protection against unwanted pregnancy and sexually transmitted infections/HIV) to women and men of reproductive age. A guide for the formulation and implementation of HIV-related messages is currently in

development for distribution throughout the region. In addition, training is being provided in the prevention of infection during client-provider interaction.

#### *Sexually transmitted infection diagnosis and treatment*

Strengthening the capacity of service providers to properly diagnose and treat sexually transmitted infections has been a key element in USAID's regional strategy. Specifically, the USAID program has tested the integration of the syndromic approach of sexually transmitted infection screening and management in family planning clinics in Côte d'Ivoire. Due to the documented limitations of using this approach in family planning clinics, the USAID Family Health and AIDS regional program is taking a lead role in shifting sexually transmitted infection control efforts in the region to focus on increasing access to and improving the quality of sexually transmitted infection services available to high-risk populations, such as migrants, sex workers and youth.

#### *Voluntary counseling and testing and hotlines*

USAID is supporting the development of voluntary counseling and testing "centers of excellence" to provide high-quality voluntary counseling and testing services and serve as training and documentation centers. In addition, USAID is assisting with development of voluntary counseling and testing training materials and national norms and guidelines in each of the Family Health and AIDS focus countries. In conjunction with voluntary counseling and testing strengthening, USAID's program will also launch telephone hotlines in the four focus countries to provide information about voluntary counseling and testing prevention and referrals.

#### *Condom promotion*

USAID's program supports a landmark prevention effort, the

PSAMAO (Prevention de SIDA sur les axes migratoires en Afrique de l'Ouest) network. This initiative is currently supporting HIV prevention and outreach efforts along migrant routes in Benin, Burkina Faso, Cameroon, Côte d'Ivoire, and Togo, and is expected to expand to at least one more country during FY 2001. Including the PSAMAO efforts, the USAID program provided support for the sale of 50.2 million condoms in 1999 and 55 million condoms in 2000 in the four FHA focus countries. USAID is also working with the World Bank and UNAIDS to develop a project focusing on HIV/AIDS prevention along the Abidjan-Lagos route.

#### **Research and surveillance**

Research is a key component for planning, implementation, and evaluation of USAID regional HIV/AIDS activities. FHA specifically supports operations research, secondary data analysis, and behavioral surveillance in the four focus countries. In addition, the USAID regional program, in partnership with a Centers for Disease Control and Prevention program in Côte d'Ivoire, provides support for African participants in a Centers for Disease Control and Prevention epidemiology course in Abidjan. The next round of demographic and health surveys will include blood tests to estimate national seroprevalences. The 12th International AIDS conference in December 2001 is receiving significant support from USAID.

#### **Care and support**

USAID implements a variety of care and support activities in the region, including technical support and capacity building of community-based care and support associations, development of guidelines for treatment and care, and training in state-of-the-art approaches for care and support.

#### **Policy dialogue**

The USAID FHA program has supported policy dialogue activity to strengthen political commitment to HIV/AIDS in the region. In 2000, a regional HIV workshop for policymakers was held in Benin. In collaboration with the Department of State, the USAID Family Health and AIDS program plans to support an HIV/AIDS meeting for U.S. ambassadors in West Africa.

#### **Capacity building**

USAID is working to build the capacity of regional partners (institutions as well as individuals) to provide high-quality and cutting-edge assistance in HIV/AIDS prevention and care and support. Capacity building plans are designed and implemented for regional institutions, and the use of African consultants is emphasized.

#### **Burkina Faso**

**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 350,000  
**Total Population:** 11.6 million  
**Adult HIV Prevalence:** 6.44%  
**HIV-1 Seroprevalence in Urban Areas:**  
 Population at High Risk: 28.6%  
 Population at Low Risk: 7.7%

#### **Cameroon**

**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 540,000  
**Total Population:** 14.7 million  
**Adult HIV Prevalence:** 7.73%  
**HIV-1 Seroprevalence in Urban Areas:**  
 Population at High Risk: 33.3%  
 Population at Low Risk: 5.5%

#### **Côte d'Ivoire**

**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 760,000  
**Total Population:** 14.5 million  
**Adult HIV Prevalence:** 10.76%  
**HIV-1 Seroprevalence in Urban Areas:**  
 Population at High Risk: 61.0%  
 Population at Low Risk: 12.1%

#### **Togo**

**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 130,000  
**Total Population:** 4.5 million  
**Adult HIV Prevalence:** 5.98%  
**HIV-1 Seroprevalence in Urban Areas:**  
 Population at High Risk: 78.9%  
 Population at Low Risk: 6.8%

#### **USAID-Supported Country Programs**

Through Population Services International/AIDSMark, USAID implements the following activities:

- ⊙ Expanding the number of voluntary HIV counseling and testing centers in Zimbabwe;
- ⊙ Broadening the role of community-based distributors of condoms;
- ⊙ Distributing, selling, and encouraging use of condoms; and
- ⊙ Building a sustainable supply of condoms.

USAID also supports management analyses and evaluations necessary to ensure sound management of



its HIV/AIDS program. These include an assessment of and assistance to public sector institutions with a view to improving their efficiency and effectiveness, and transparent management of the National AIDS Council, and the Demographic Health Survey planned for FY 2004.

This year, the Mission will begin to work to strengthen advocacy initiatives and develop positive HIV/AIDS-related policy in the public sector through nongovernmental organizations and faith-based organizations. In collaboration with the Centers for Disease Control and Prevention, USAID

will support improved information and data collection for advocacy and policy change.

In addition, USAID will launch initiatives to sustain and replicate community programs to assist children affected by AIDS and to increase economic opportunity for youth affected by AIDS.



Photo: Plan/Watson CINI

## *Latin America and the Caribbean*

Latin America and the Caribbean are home to a number of nations such as Haiti and the Bahamas, where HIV/AIDS prevalence levels are higher than in any other countries outside of sub-Saharan Africa. By the end of 1999, UNAIDS estimated that 1.8 million adults and children were living with HIV/AIDS in the region, accounting for 5 percent of the world's total. An estimated 65,000 adults and children in Latin America/Caribbean have died of AIDS since the beginning of the epidemic, accounting for 3 percent of the world's cumulative AIDS-related deaths.

In 1999, UNAIDS lowered its estimate of the total number of persons living with HIV/AIDS in Latin America/Caribbean because prevalence had stabilized or declined in the region's two biggest countries, Brazil and Mexico. However, prevalence levels in four countries—the Bahamas, Guyana, Haiti, and Honduras—remain above 3 percent, with Haiti at 7 percent in 2000.

HIV prevalence in the region will continue to grow through 2010, according to the U.S. Census Bureau, although no country is predicted to exceed the 10 percent prevalence mark. Barbados, Belize, Dominican Republic, and Suriname have adult HIV prevalence rates of more than 1 percent. In Guyana, the U.S. Census Bureau reports negative population growth (−0.1 percent), in part due to AIDS and in part due to migration out of the country.

Across the region, the effect of the pandemic on life expectancies has not been as great as in sub-Saharan Africa due to lower HIV prevalence rates. However, life spans are still lower than they would have been without HIV/AIDS. In the Bahamas, life expectancy is now 71 years (instead of 80), and Haitians can expect to live to age 49 (instead of 57). By 2010, crude death rates in the Bahamas and Guyana will be twice the rates predicted without AIDS, and infant and child mortality rates are

already 2 to 6 percent higher than without AIDS. In the Bahamas and Guyana, AIDS will cause more than half of childhood deaths by 2010.

Brazil, where adult prevalence remains below 1 percent, dominates regional statistics due to its large population. The country accounts for 34 percent of the region's total population, 36 percent of adults and children living with HIV/AIDS, and 44 percent of cumulative deaths. In this sense, it commands a similar position over regional AIDS statistics as do India and China in Asia. However, Brazil's epidemic is different because it has occurred primarily among men who have sex with men and injecting drug users—the same pattern found in most industrialized countries.

Over the past few years, the regional epidemic has shown an increase in heterosexual transmission, and a larger proportion of HIV infections occur among women. HIV transmission in Central America and in the Caribbean occurs primarily through heterosexual contact, while men who have sex with men and injecting drug users account for the majority of HIV infections in many countries in South America. Vertical transmission has emerged as a concern in Dominican Republic and Honduras, prompting greater focus on preventing HIV infection in pregnant women, while the Mexican epidemic is fueled primarily by men who have sex with men, 14 percent of whom are infected.

Dominican Republic and Haiti have led the region in HIV infection rates among pregnant women: in Haiti, 8 percent of pregnant women tested HIV positive in 1993, and in Dominican Republic, 8 percent tested positive at one site in 1996. In Guatemala, 2 to 4 percent of pregnant women tested positive in urban area clinics, and infection rates have reached 1 percent among pregnant women in parts of Brazil and in Honduras. Up to 46 percent of women sex workers in Guyana and more than 7 percent of pregnant women have tested positive for HIV. Higher contraceptive use among women in Latin America/Caribbean, together with lower pregnancy rates, makes antenatal clinic surveillance data less representative of the epidemic than in Asia or sub-Saharan Africa.

In 1986, only one AIDS case of every 17 in the world occurred among women. In 1998, the figure was one in four. For the Latin American/Caribbean region, one in five, or 20 percent, of all AIDS cases occur among women. The epidemic is also shifting its economic base, moving from the educated and middle class to the poorer and less educated. Today, 60 percent of those living with HIV/AIDS did not study beyond primary school.

Early sexual activity, high rates of partner exchange, and age mixing (i.e., younger women having sex with older men) contribute to the heterosexual spread of HIV in the Caribbean. At one antenatal clinic in Jamaica, girls in their teens were found to have twice the HIV prevalence of older women.

In South America's "Southern Cone" nations, such as Chile and Argentina, injecting drug use has played a critical role in the spread of HIV/AIDS, while nations of the Andean region remain relatively unaffected by the epidemic. In Bolivia and Peru, for example, HIV prevalence rates in pregnant women range from 0.2 to 0.5 percent.

Brazil, with more than half a million HIV-infected residents, is viewed as a regional model for responding to the epidemic. The government has implemented strong prevention programs that have led to widespread acceptability of condom use, and recently began providing antiretroviral therapy at no cost to all persons living with HIV/AIDS.

## Youth Participation

Involving young people in helping to determine HIV/AIDS-related policy, and to design and implement programs, is a critical part of the Latin American/Caribbean approach to HIV prevention. Youth involvement will be particularly important in preventing a second-generation pandemic.

The youth component of the regional response to HIV/AIDS has been dominated by prevention education and behavior change concepts, with a focus on life skills. Many volunteer youth peer education efforts are underway throughout the region, and stronger collaboration between health, education,



and youth officials has yielded a wider array of both in-school and out-of-school HIV/AIDS education initiatives. One example is Guyana's Commonwealth Youth Programme, which builds capacity among youth and provides forums for youth and government ministers to engage in discussion about HIV/AIDS.

The Caribbean Community has recently partnered with the United Children's Fund, the Rotarians, and national governments to organize several conferences on youth and HIV/AIDS, and the Peace Corps remains active in youth development in Latin American countries, implementing a variety of life skills education and HIV/AIDS prevention efforts.

### USAID Mission Activity

Since 1992, USAID's Latin America/Caribbean Bureau has focused its efforts in HIV/AIDS prevention in Brazil, Dominican Republic, Guyana, Haiti, Honduras, Jamaica, and Mexico. Field

Missions in Bolivia, Peru, and Nicaragua have also implemented country-specific prevention activities, and USAID's Central American regional office is currently carrying out a subregional HIV/AIDS prevention program that addresses HIV/AIDS issues throughout Central America across national borders. Mexico has funded a new initiative to work with migrant populations throughout Central America.

Mission programs are also established in El Salvador, Guatemala, and there is a new regional program in the Eastern Caribbean. The programs work with men who have sex with men and commercial sex workers and in-school and out-of-school youth. Programming in the region includes: the use of theater and dramatic arts to disseminate prevention messages, peer education, and mass media behavior communication. Much effort is focused on working on policy, strengthening non-governmental organizational capacity and working with persons living with HIV/AIDS.

## Bolivia

With 287 AIDS cases reported as of May 2001, Bolivia remains on the margin of the epidemic in Latin America. According to Ministry of Health statistics, 605 persons were living with HIV/AIDS in May 2001, with most residing in the urban centers of Santa Cruz, La Paz, and Cochabamba. Sexual transmission accounted for 87 percent of these cases, while mother-to-child transmission and transmission through blood and blood products accounted for 5 percent and 8 percent, respectively. Reported sexual orientation among those infected with HIV has changed over the 16-year period for which data are available. Between 1985 and 1992, 5 percent of those infected reported themselves as heterosexual, 80 percent as homosexual, and 15 percent as bisexual; whereas 61 percent of those infected between 1993 and 2001 self-reported as heterosexual, 20 percent as homosexual, and 19 percent as bisexual.

The male-to-female ratio of new infections also reflects a shift in transmission patterns. From 1985 to 1992, the ratio was 10 men for every one woman infected; during the period 1993 to 2001, the ratio changed to 3:1. A 2000 sentinel surveillance study among the general population in the three largest cities found that less than 0.1 percent were HIV-positive. In December 2000, a 0.3 percent rate of HIV infection was reported among female sex workers in Santa Cruz, a city that currently accounts for 51 percent of HIV cases in Bolivia.

Although HIV prevalence is low, high rates of sexually transmitted infections among female sex workers are a cause for concern. As of 2000, prevalence rates for syphilis, gonorrhea, and chlamydia in this group were 7.82 percent, 4.4 percent, and 10 percent, respectively.

Prevalence rates for syphilis and gonorrhea in the general population were 0.1 percent and 0.14 percent, respectively, in 2000.

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**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 605

**Total Population:** 8 million

**Adult HIV Prevalence:** >0.1%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 0.3%

Population at Low Risk: >0.1%

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### USAID Strategy

The USAID/Bolivia strategy for AIDS programming consists of supporting public education and information campaigns and condom social marketing through local nongovernmental organizations and a national social marketing project, and strengthening capacity for diagnosis and treatment of sexually transmitted infections, primarily through the public sector service delivery system. USAID has been and continues to be the major source of support for the National AIDS Program of the Ministry of Health and its sexually transmitted infection and AIDS control strategy.

### USAID-Supported Country Programs

#### *Treatment/control of sexually transmitted infections*

Through Proyecto de Salud Integral, USAID's health sector bilateral agreement with the Government of Bolivia, support is provided for a national network of laboratories and sexually transmitted infection clinics, training and supervision of health personnel, and research. The clinics, established in all nine departmental capitals plus the city

of El Alto, offer clinical exams and laboratory diagnosis for major sexually transmitted infections, counseling and testing for HIV, and education on sexually transmitted infections and AIDS prevention. This same constellation of sexually transmitted infection and AIDS services is being developed in key frontier towns on the Brazilian and Argentinean borders and in interior towns with a high level of commercial sex activity serving large migrant worker populations. In 2001, four frontier zone clinics for treating sexually transmitted infections and AIDS will be established and maintained in Cobija, Guayaramaren, and Puerto Quijaro on the Brazilian border, and in Yacuiba on the Argentinean border. Two additional clinics in towns with migrant worker populations will be established in Caranavi and El Chapare.

### Surveillance

The most significant of the research efforts supported by USAID is a network of sexually transmitted infection and AIDS sentinel surveillance sites. All 10 of the country's regional sexually transmitted infection clinics report incidence data among female sex workers and the general population. Three additional sites in La Paz, Cochabamba, and Santa Cruz gather incidence data on the general population. Additional research supported by USAID includes periodic sexual behavior studies, studies to track the drug resistance of gonorrhea, and validation studies of sexually transmitted infection syndromic management.

### Condom social marketing

Population Services International implements a condom social marketing program and public information and education campaigns on sexually transmitted infections and AIDS. Condoms are sold through a national distribution network of approximately 3,000 points of sale that include pharmacies,

supermarkets, sporting goods stores, music stores, liquor stores, brothels, bars, discotheques, and nightclubs. Population Services International also works with local nongovernmental organizations to sell condoms through their community-based distribution systems.

Female condoms are sold primarily in pharmacies and brothels. Condom promotion activities include television and radio advertisements, billboards, sponsoring of sports teams, and promotional give-aways.

### ***Information, education, and communication***

Population Services International/AIDSMark disseminates sexually transmitted infection and AIDS prevention information through nationwide communication campaigns that include television and radio miniseries, radio call-in shows, an annual songwriting contest and concert tour, and informational videos and print material. More targeted educational activities are carried out with special population groups, including the military, the police, truck drivers, and migrant workers. Mobile video units are used to reach rural populations.

USAID further supports sexually transmitted infection and AIDS prevention education and information activities through local nongovernmental organizations. Prosalud, Centro de Investigación, Educación y Servicios, and CARE Bolivia carry out community-level interventions in the major urban centers, with special focus on female sex workers, men who have sex with men, university and high school students, and police and military personnel. Centro para Programas en Comunicación implements a telephone hotline on sexual health that is promoted heavily as a source of information on sexually transmitted infections and AIDS.

## **Brazil**

Brazil continues to be a regional epicenter for HIV/AIDS, accounting for approximately 52 percent of reported AIDS cases in Latin America and the Caribbean. An estimated 560,000 to 850,000 Brazilians were living with HIV/AIDS at the end of 1999. Although the overall incidence of HIV has leveled off since 1997, transmission through heterosexual contact and injecting drug use appears to be on the rise. At the end of 1999, 28.7 percent of cumulative AIDS cases in Brazil were due to homosexual or bisexual transmission; 23.6 percent to heterosexual transmission; and 19.3 percent to injecting drug use.

The Brazilian epidemic is concentrated in urban areas; the states of São Paulo and Rio de Janeiro account for more than 65 percent of the nation's HIV/AIDS infections. HIV prevalence among pregnant women tested in 1998 was 0.4 percent. Among those seeking treatment for sexually transmitted infections, 3.7 percent of men and 1.7 percent of women tested positive for HIV. In 1999, the male-to-female ratio of reported AIDS cases was 2.08:1.

Recent studies have indicated significant changes in sexual behavior among Brazilians. A 1999 survey of 3,500 adults showed that about half of young men reported using a condom the first time they had sex—a steep increase from 1986, when only 5 percent of men reported condom use at sexual debut.

Brazil is one of a handful of countries in Latin America to guarantee free access to antiretroviral therapy and treatment for opportunistic infections. By February 2000, about 85,000 Brazilians living with HIV/AIDS were receiving treatment provided by the Ministry of Health.

**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 540,000

**Total Population:** 168 million

**Adult HIV Prevalence:** 0.57%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 6.0%

Population at Low Risk: 2.6%

### ***USAID Strategy***

USAID/Brazil's strategic objective is designed to prevent transmission of HIV among women, adolescents, and low-income populations. The Mission is working to achieve three results: 1) strengthened institutional capacity to plan, implement, and evaluate programs for HIV and sexually transmitted infections; 2) strengthened institutional capacity to provide integrated health services in Bahia and Ceara; and 3) sustainable condom social marketing.

USAID's HIV/AIDS strategy is closely linked to the programs of the Brazilian Ministry of Health and involves integration of HIV and sexually transmitted infection prevention activities with health services and at-risk youth programs in four target areas: São Paulo, Rio de Janeiro, Bahia, and Ceara.

USAID/Brazil has also begun a dialogue with other Missions in the subregion on possible collaborative activities to curb cross-border transmission of HIV.

### ***USAID-Supported Country Programs***

USAID-supported programs include activities in condom social marketing; operations research to identify, disseminate, and promote the adoption of effective interventions; and capacity building to strengthen management skills of nongovernmental organizations



and local governments.

Recent achievements include:

- ⊙ Introduction of the female condom in 1997. Condoms are now available at Brazilian pharmacies.
- ⊙ Introduction of low-price "Prudence" condoms. USAID support has contributed to the expansion of Brazil's condom market which, through competition, has led to lowered prices of all brands of condoms.
- ⊙ Increased effectiveness of delivery of HIV/AIDS and sexually transmitted infection services in Bahia and Ceara. More than 120 health professionals have been trained to integrate prevention and health care services. As a result, more than 10,000 women are benefiting from integrated services in 20 health units in Bahia and Ceara.
- ⊙ Training of 200 teenagers to disseminate HIV/AIDS information through art education activities. This initiative was implemented by the Acquired Resistance Project in Rocinha Slum, Rio de Janeiro.

Cooperating agencies active in HIV/AIDS programming include Family Health International/IMPACT, Population Council/Horizons, Population Services International/AIDSMark, Pathfinder do Brasil, DKT do Brasil, and Management Sciences for Health.

## Dominican Republic

According to the Dominican Republic's National Program for the Control of HIV/AIDS, 150,000 to 170,000 persons—or 2.5 percent of the adult population—were infected with HIV as of 2000.

This estimate indicates that the country's infection rate has reached a plateau, showing a decline from earlier prevalence projections of about 4.5 percent. However, fewer than 5 percent of Dominicans infected with HIV are aware of their serostatus. Thirteen sentinel surveillance sites throughout the country have reported that more than 2 percent of pregnant women are HIV-positive; Puerto Plata and La Romana have reported infection rates of 8 and 5 percent, respectively. Infection rates for commercial sex workers range from 3.5 to 9.5 percent, while 4.3 percent of patients with sexually transmitted infections are HIV-positive.

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<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>	
<b>Total Population:</b>	130,000
<b>Adult HIV Prevalence:</b>	8 million
<b>HIV-1 Seroprevalence in Urban Areas:</b>	2.8%
Population at High Risk:	3.9%
Population at Low Risk:	1.4%

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### USAID Strategy

USAID/Dominican Republic provides assistance to the National Program for the Control of HIV/AIDS in developing and implementing mother-to-child HIV prevention programs, voluntary counseling and testing programs, and prepackaged therapy for sexually transmitted infections. The Mission also assisted with development of the National Strategic Plan for HIV/AIDS Prevention for 2000–2003, which has served as a framework for drafting 26 provincial and municipal action plans. The Mission continues to expand youth outreach in HIV/AIDS prevention and education and works closely with

UNAIDS and the European Union to support mother-to-child transmission programs, implement mass media campaigns, and advocate for policy reforms.

The Mission revised its HIV/AIDS strategy in 1999 to focus on increasing the use of primary health care services. Its main objectives are to 1) increase risk perception and health-seeking behavior among the most vulnerable populations, 2) implement successful pilot community-based programs in support of people living with HIV/AIDS, and 3) increase access by at-risk populations to information and services on HIV and sexually transmitted infections.

### USAID-Supported Country Programs

Country programs have been implemented by the Academy for Educational Development, AccionSIDA Project, and the National Program for the Control of STIs/AIDS. The AccionSIDA project is being implemented through 15 subgrants to non-governmental organizations covering a variety of prevention activities, including control of sexually transmitted infections and programs to support people infected and affected by HIV. These interventions cover a wide geographic area and have a strong presence in 23 of 29 provinces. At the national level, grants to the National AIDS Coalition and the National Health Institute are supporting the advancement of a national policy platform.

### Workplace interventions

The Centro de Orientación y Investigación Integral has carried out HIV/AIDS education programs aimed at industrial workers since 1991. Since 1995, Centro de Orientación y Investigación Integral peer educators have reached approximately 70,900 workers and have provided more than 15,000 sexually transmitted

infection consultations. This project will be extended until March 2002 under the AccionSIDA Cooperative Agreement.

A 1995–1999 HIV/AIDS education project implemented by the Comité de Vigilancia Contra el SIDA reached approximately 13,000 hotel employees and managers in the Playa Dorada Resort, Puerto Plata.

#### *Young adults*

Since 1997, the AED/AccionSIDA project has provided grants to the Asociación Dominicana de Planificación Familiar, the Coordinadora de Animación Socio-Cultural, and the Asociación Pro Bienestar de la Familia, as well as to the Instituto de Desarrollo Integral and Mujeres en Desarrollo Dominicanas (MUDE), to implement prevention activities for youth and adolescents. These activities promote behavior change through information and educational campaigns, training of peer educators, workshops, and community events. The projects have reached more than 62,640 direct beneficiaries (adolescents and youth aged 10 to 19); 620 community leaders; 246 community-based organizations; and 250,591 parents, tutors, and teachers.

#### *Commercial sex workers*

Since 1995, HIV/AIDS programs implemented by Centro de Orientación y Investigación Integral and Centro de Promoción y Solidaridad Humana have targeted commercial sex workers, their clients, and brothel and bar owners. Centro de Orientación y Investigación Integral projects are under way in Santo Domingo, La Romana, Santiago, and San Cristobal, while Centro de Promoción y Solidaridad Humana operates in Puerto Plata and five other municipalities located in the Cibao area. Both of these programs have provided training and support in empowerment and group organization for commercial sex work-

ers and have worked to promote the "100% Condom Policy" in 316 motels, brothels, and bars. As a result, they have reached more than 107,200 beneficiaries, and have trained more than 407 health educators.

#### *Men who have sex with men*

Since 1991, Amigos Siempre Amigos has implemented programs to promote behavior change and raise awareness of HIV/AIDS among men who have sex with men. Seventy-three percent of participants in Amigos Siempre Amigos workshops reported condom use during the last five sexual contacts.

#### *Networks for persons living With HIV/AIDS*

The Red Dominicana de Personas que Viven con el VIH was created in 1999 to provide legal and social assistance to persons living with HIV/AIDS and to defend the legal and human rights of seropositive persons at the national level. The organization has also provided training on the national AIDS law to judges and attorneys in the Dominican Republic.

The Grupo de AutoApoyo CLARA provides educational and support programs for persons living with HIV. The Grupo developed a network of more than five support groups for HIV-infected persons in the province of Puerto Plata. In addition, the group has set up a self-help facility at a public health hospital in Puerto Plata where medical and psychological services are provided, and pretest and posttest counseling is available for the general population.

Both groups have reached a total of 5,000 beneficiaries, developed 19 self-help groups nationwide, and have reached agreements with public health hospitals and the Dominican Red Cross. They also receive support from the Joint United Nations Programme on HIV/AIDS and the European

Community.

#### *Sexually transmitted infections*

In 1998, the Mission signed a limited-scope agreement with the Dominican Government to begin a process of institutional strengthening within the National AIDS Program. The activity provides technical assistance and training to enable the National AIDS Program to assume leadership as the coordinating body in the Dominican Republic. As a result of the program, sexually transmitted infection norms have been disseminated. Syndromic management training manuals have been developed, and an agreement was reached with a local university, Instituto Tecnológico de Santo Domingo, to conduct training in syndromic management for more than 150 service providers. Medical and laboratory equipment has also been provided to 12 sexually transmitted infection service facilities.

Population Services International/AIDSMark is conducting a pilot project to assess the feasibility of implementing prepackaged therapy for sexually transmitted infections. Based on the results of the project, the program will expand to provide prepackaged therapy to other hospitals.

#### *Mother-to-child transmission/voluntary counseling and testing*

In response to a National AIDS Program request, Family Health International/IMPACT has begun providing support for voluntary counseling and testing programs at the two main maternity hospitals in Santo Domingo and at a general hospital in Puerto Plata. The three hospitals have started to offer voluntary counseling and testing and mother-to-child transmission prevention counseling in private rooms. In 2001, Family Health International/IMPACT plans to provide technical assistance and training to select counselors and will develop a counseling protocol.

## El Salvador

Approximately 25,000 people were estimated to be living with HIV/AIDS in El Salvador in 2000, with 3,481 AIDS cases diagnosed, and 3,337 cases of HIV detected.

Ministry of Health data from the year 2000 show that the ratio of HIV-infected men to women is 3 to 1, and youth (aged 15 to 24) are experiencing the fastest growing rate of infection.

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### Estimated Number of Adults and Children Living with HIV/AIDS, end of 2000:

25,000

### Total Population:

6 million

### Adult HIV

#### Prevalence:

0.6%

### HIV-1 Seroprevalence in Urban Areas:

#### Population at High Risk:

0.5%

#### Population at Low Risk:

0.5%

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### USAID Strategy

USAID's strategy seeks to support civil society by applying a systematic approach to HIV prevention and related behavior change interventions. The strategy includes surveillance and voluntary counseling and testing activities focusing on vulnerable groups such as the military, prisoners, men who have sex with men, and the national civilian police.

### USAID-Supported Country Programs

Beginning in 1999, USAID/El Salvador incorporated an AIDS component into its bilateral "Healthy Salvadorans" activity. To date, USAID-funded activities have supported the development of a National HIV/AIDS Program; development of HIV/AIDS treatment protocols and sexually transmitted infection norms; and the

provision of technical assistance through training health personnel from nongovernmental organizations and the Ministry of Health in HIV/AIDS counseling, management of syphilis, pediatrics, and HIV/AIDS. Ministry of Health counterparts are also in the final process of establishing an HIV/AIDS hotline with USAID/El Salvador financing, and USAID has supported HIV/AIDS legislation, which is ready to be introduced in the National Assembly.

USAID/El Salvador is working closely with the Central American HIV/AIDS Prevention Project (Proyecto Acción SIDA de Centroamérica, or PASCA), which completed a study in the port of La Libertad to assess sex workers' knowledge and attitudes toward HIV/AIDS. This information was used to begin organization of a community-based HIV prevention activity based on the "Cadena de Cambio" model. The project is also carrying out a multisite study that will measure HIV prevalence in the Acajutla harbor and in San Salvador among vulnerable groups. Through the Pan American Social Marketing Organization, USAID works with local nongovernmental organizations to promote correct and consistent condom use among high-risk areas and groups.

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## Guatemala

The Guatemalan epidemic is spread primarily through sexual activity, which accounts for 93 percent of all AIDS cases. Of the 4,086 AIDS cases reported as of March 2001, 2 percent were attributed to blood transfusions, and 4.5 percent to mother-to-child transmission. Seventy-five percent of cases occurred in men. According to a Ministry of Health estimate, an estimated 40,000

Guatemalans were living with HIV/AIDS as of 2001. In recently initiated sentinel surveillance studies, HIV prevalence ranged from 2.5 percent among sex workers in Guatemala City, to as high as 9 percent to 11 percent among a smaller number of sex workers in the Department of Izabal.

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### Estimated Number of Adults and Children Living with HIV/AIDS, March 2001:

4,086

### Total Population:

11.5 million

### Adult HIV

#### Prevalence:

1.38%

### HIV-1 Seroprevalence in Urban Areas:

#### Population at High Risk:

2.3%

#### Population at Low Risk:

0.4%

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### USAID Strategy

USAID has been an important donor to HIV/AIDS prevention activities through support for development of information, education, and communication materials; training manuals; and policy dialogue on the national AIDS law, which was approved in 2000. The Mission continues to provide condoms to the sexually active population and the most vulnerable groups through its implementing agencies, the Ministry of Health's Reproductive Health Unit, the Ministry of Health's National AIDS Control and Prevention Program, the Social Security Institute, and small local private voluntary organizations working with high-risk groups.

### USAID-Supported Country Programs

Beginning in 2001, USAID supports assistance from the Centers for Disease Control and Prevention to the Ministry of Health in Guatemala to establish a national



HIV/AIDS surveillance system in order to measure the effect on the epidemic of national prevention and mitigation programs.

The USAID regional program, through its implementing agency, the Central American AIDS Action Project, strengthens the capabilities of Central American organizations to deliver HIV/AIDS services and information to target groups through training and targeted technical assistance, and by facilitating exchange of experiences, information, skills, and resources across countries. It provides assistance for strategic alliance building and proactive information dissemination for advocacy and policy dialogue. The condom social marketing component of the regional program emphasizes behavior change in high-risk groups and improved condom access and availability through affordable pricing and distribution through multiple channels and outlets. The implementing agency for this component is the Pan American Social Marketing Organization.

USAID also actively participates in the Joint United Nations Programme on HIV/AIDS Expanded Country Theme Group promoting intersectoral collaboration in AIDS programming, policy dialogue, information dissemination, and public awareness.

## Guyana

Although Guyana now has the second highest HIV prevalence rate in the Latin American/Caribbean region, the government and donors have been slow to respond to the problem. Heterosexual transmission accounts for approximately three-fourths of AIDS cases, and HIV prevalence in the general population is estimated at 5 to 7 percent. A 1996 study found that

more than 7 percent of pregnant women in urban Guyana were HIV-positive, while 1997 data showed that 18 to 25 percent of patients with sexually transmitted infections were infected. Studies of sex workers in the capital city of Georgetown have found infection rates of up to 46 percent.

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### Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:

	15,000
<b>Total Population:</b>	900,000
<b>Adult HIV Prevalence:</b>	3.01%
<b>HIV-1 Seroprevalence in Urban Areas:</b>	
Population at High Risk:	43.6%
Population at Low Risk:	3.8%

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### USAID Strategy

USAID/Guyana's five-year, \$1.2 million HIV/AIDS strategy began in October 1999, with Family Health International as the major implementing partner. The strategy aims to 1) increase knowledge of HIV/AIDS and sexually transmitted infections among targeted groups, 2) increase the number of people receiving quality services from USAID-assisted nongovernmental organizations, and 3) increase condom use among targeted groups.

### USAID-Supported Country Programs

Working with Family Health International, USAID/Guyana has funded six indigenous nongovernmental organizations to work collaboratively to develop awareness, knowledge, and prevention strategies. This initiative—the Guyana HIV/AIDS/STI Youth Project—is operational in three urban centers in Guyana and targets youth aged 8 to 25, who are outside the country's formal education system. Activities

include campaigns to promote self-risk assessment, identify and train peer educators, and expand peer education networks. "Ready Body: Is It Really Ready?" is the theme of the self-risk assessment component. Nongovernmental organizations are using music, street theater, talk shows, and marches to engage youth and spread prevention messages. Street fairs with HIV/AIDS prevention themes have been held in three major cities, and a World AIDS Day play is planned.

The Guyana HIV/AIDS/STI Youth Project plans to scale up its prevention network in FY 2001 by expanding to other nongovernmental organizations and focus populations, such as religious organizations, parent groups, unions, and mining communities. USAID will also conduct a condom supply and distribution assessment in FY 2001 to strengthen the current distribution system and guide development of a condom social marketing program.

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## Haiti

With HIV infection rates of up to 10 percent in urban areas and 6.6 percent in the general population, Haiti is the most affected country in the region and has emerged as the country with the highest HIV infection rates outside of Africa. Poverty, conflict, and unstable governance have hastened the spread of HIV/AIDS. The Haitian epidemic can be attributed primarily to heterosexual transmission, and cases are concentrated among young adults. At the end of 1999, approximately 210,000 Haitians were living with HIV/AIDS, and the disease has orphaned about 160,000 children. Thirteen percent of pregnant women tested positive for HIV in 1996.

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**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:**

210,000

**Total Population:**

8 million

**Adult HIV Prevalence:**

5.17%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk:

N/A

Population at Low Risk:

10%

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**USAID Strategy**

In 1995, USAID/Haiti developed an integrated health program, the Health Systems 2004 Project, to increase the effectiveness of its assistance to nongovernmental organizations and to provide assistance to the public sector. USAID's current HIV/AIDS program in Haiti includes a comprehensive set of prevention, education, and care and support activities. The United States is the largest donor to HIV/AIDS activities in Haiti.

**USAID-Supported Country Programs**

USAID/Haiti is supporting Family Health International/IMPACT to implement the following activities

- ⊙ A behavior surveillance survey,
- ⊙ Voluntary counseling and testing programs,
- ⊙ Prevention and education programs aimed at high-risk groups (i.e., adolescents, orphans and vulnerable children, commercial sex workers) and people living with HIV/AIDS, and
- ⊙ A national public awareness campaign.

The Mission also supports the Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections to carry out a voluntary counseling and testing program. The group trains social workers to inform and support

individuals with HIV, and has established a system for coordinating counseling activities with other health service agencies.

In addition, CARE is implementing a care and support program for people living with HIV/AIDS, using an integrated family/community approach.

**Condom social marketing**

Population Services International/AIDSMark is carrying out a highly successful condom marketing initiative in Haiti. The "Pante" condom is widely promoted and is sold locally for less than 20 percent of the price of popular commercial brands. Pante sales have increased steadily since the condom was introduced in 1992 and more than 32 million have been sold. From January to June 2000, Population Services International/AIDSMark sold 5,529,654 units, which represents a 47 percent increase compared with the same period in 1999. Population Services International/AIDSMark recently implemented a pilot project to introduce female condoms and has sold more than 12,000 units in less than a year. In addition, the group has introduced a socially marketed packet for sexually transmitted infection treatment using the syndromic approach approved by the Ministry of Health.

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## Honduras

HIV prevalence rates in Honduras are the highest in Central America, and the country now accounts for more than half of all AIDS cases in the subregion. The epidemic is fueled by heterosexual transmission, which accounted for 83 percent of reported AIDS cases as of September 2000. Mother-to-child transmission is also on the rise, accounting for 6 percent of AIDS cases reported as of December 2000. About 48 percent of reported

AIDS cases are found in the two urban centers, San Pedro Sula and Tegucigalpa. Studies of sex workers in San Pedro Sula have indicated infection rates of 10 percent or more.

In the late 1990s, the annual number of reported AIDS cases stabilized at around 1,000, and prevalence has leveled off at about 1.9 percent of the adult population. It is important to note that reported AIDS cases are believed to be substantially lower than the actual number of AIDS cases in Honduras.

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**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:**

63,000

**Total Population:**

6 million

**Adult HIV**

**Prevalence:**

1.92%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk:

13%

Population at Low Risk:

5%

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**USAID Strategy**

Through 2000, USAID/Honduras focused on HIV/AIDS prevention, with special emphasis on young adults aged 15–24 and commercial sex workers. Beginning in 2001, the new Mission strategy will focus on strengthening prevention in high-prevalence groups, such as commercial sex workers, men who have sex with men, and the Garifuna community. In addition, a self-sustaining condom social marketing program is being implemented, and the use of new-generation rapid HIV tests will soon be promoted. The goal of the USAID HIV/AIDS prevention program in Honduras is to interrupt further transmission from high prevalence populations into the general population.

### **USAID-Supported Country Programs**

The Mission's HIV/AIDS strategy incorporates both private and public sector components. The private sector component is managed by the Fundación Fomento en Salud, a local nongovernmental organization that provides subgrants to approximately 15 nongovernmental organizations working with high prevalence populations. The public sector component is managed by the Ministry of Health, which receives USAID funds to conduct surveillance activities and special studies on HIV/AIDS and sexually transmitted infections, as well as pilot activities to prevent mother-to-child transmission.

Family Health International/IMPACT provides technical assistance to the Fundación Fomento en Salud to build capacity. The Mission also provides funds to the Population Services International/AIDSMark project to support the establishment of a condom promotion/social marketing program through the services of the Pan-American Social Marketing Organization. In addition, the Mission supports development of a national AIDS communication strategy/campaign with assistance from Johns Hopkins University.

Finally, USAID supports the Centers for Disease Control and Prevention in providing technical assistance to the Honduran Ministry of Health to improve national surveillance capabilities.

## **Jamaica**

At the end of 1999, an estimated 9,900 Jamaicans were living with HIV/AIDS. The disease is spread primarily through heterosexual activity, which accounts for 49 percent of cases, but mother-to-child transmission is also a concern,

accounting for 6.5 percent of cases. HIV prevalence among pregnant women is in the 1–2 percent range, and 7 percent of patients with sexually transmitted infections tested positive for HIV in 1997. A 1994–95 study found a 25 percent infection rate among sex workers in the tourist area of Montego Bay, while 1996 data show a 9 percent infection rate for sex workers in the capital city of Kingston.

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<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>	9,900
<b>Total Population:</b>	3 million
<b>Adult HIV Prevalence:</b>	0.71%
<b>HIV-1 Seroprevalence in Urban Areas:</b>	
Population at High Risk:	6.4%
Population at Low Risk:	1.0%

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### **USAID Strategy**

USAID/Jamaica supports the Ministry of Health in implementing two programs to address HIV/AIDS: the HIV/AIDS/STI Prevention and Control Program (1988–2001) and the Adolescent Reproductive Health Project (1999–2004). The former program began with the goal of reducing transmission, and the incidence and prevalence of HIV and other sexually transmitted infections in Jamaica. Activities are focused on strengthening three key areas: 1) the Ministry of Health HIV/AIDS/STI surveillance program, 2) public education programs, and 3) interventions that target high-risk groups. The program shifted its focus slightly in 1996 to "reduce the rate of increase in transmission of HIV and the incidence and prevalence of sexually transmitted infections in Jamaica." Program activities expanded to include the components listed below.

### **Behavior change communication**

The program's major component, behavior change communication activities, addresses lifestyle issues that lead to high-risk behavior, which may include multiple partnerships, especially casual relationships, and lack of condom use. Activities target high-risk groups and incorporate mass media prevention strategies as well as counseling for persons with HIV/AIDS and sexually transmitted infections. Issues that inhibit condom use among men and women are also addressed.

### **Community peer educators**

Community peer educators play a major role in the behavior change communication component. They conduct community-level prevention and education programs on HIV and sexually transmitted infections using a variety of innovative approaches including drama and video presentations, rap sessions with small groups, and face-to-face discussions. The primary objective is to increase condom use and reduce the number of sexual partners among high-risk groups. Community peer educators are also responsible for monitoring the development of condom distribution systems in their communities.

Other interventions focus on sensitizing and training health workers, particularly physicians, in pre- and post-HIV test counseling; developing linkages and programs with the Ministry of Education to train school nurses and counselors in the area of HIV/AIDS and other sexually transmitted infections; and training in research and evaluation methods.

Mass media campaigns are ongoing and focus on prevention messages (condom use) as well as strong abstinence messages for adolescents. The 2000 campaign theme was: "AIDS is in Jamaica. ...Let's face it together." An AIDS/STI helpline has been established and continues to be heavily used.



### ***Sexually transmitted infection control***

Activities focus on reducing sexually transmitted infections as a cofactor in the transmission of HIV infection among high-risk individuals. Treatment centers were established in each of Jamaica's 13 parishes, and health workers have received training in case management. This component has been highly successful in reducing the number of infectious syphilis cases, which showed a 40 percent decrease during the first six months of 1999 compared with the first six months of 1998.

HIV sentinel surveillance sites were established early in the program in antenatal and sexually transmitted infection clinics. Recently, sentinel sites have expanded to include hotel workers, family planning clients, and commercial sex workers.

### ***Condom social marketing***

Because condom use is an integral part of all efforts to prevent and control HIV and sexually transmitted infections, USAID/Jamaica supports efforts to increase consistent demand and supply of condoms and promote sustained use. Approximately 2,000 new, nontraditional condom outlets (e.g., bars, beauty shops, and street vendors) have been established islandwide.

### ***Epidemiology***

Interventions focus on strengthening the management capability of the Ministry of Health Epidemiology Unit to enhance the efficiency and effectiveness of the National AIDS Program. Capacity-building has been supported through management and technical skills training as well as team-building workshops.

### ***National AIDS Committee***

The National AIDS Committee was established in 1988 with a mandate to develop a program of public education for the control and spread of HIV/AIDS in

Jamaica. Its role has expanded to include advocacy activities and to coordinate and support Parish AIDS Committees. USAID assists the National AIDS Committee with 1) facilitating national policy formulation and public awareness, 2) mobilizing private sector support and raising funds for HIV/AIDS activities and parish AIDS committees, and 3) strengthening the National AIDS Committee's efforts in coordinating and mobilizing its member organizations and subcommittees.

## **Mexico**

HIV infection in Mexico continues to be concentrated among men who have sex with men, 14 percent of whom are infected. At the end of 2000, between 116,000 and 177,000 Mexicans were living with HIV, and 47,617 cases of AIDS had been reported to UNAIDS. The highest number of infections occurs in the 25- to 44-year age group. AIDS is the third most common cause of death among Mexican men and the sixth leading cause of death among women. In 2000, the male-to-female ratio of AIDS cases was 6:1.

According to statistics gathered by the Pan American Health Organization, homosexual and bisexual transmission accounted for 53.6 percent of cumulative AIDS cases as of December 2000, while heterosexual transmission accounted for 33.1 percent of cases. Injecting drug use was linked to only 0.9 percent of AIDS cases, but the mode of transmission for a substantial number of cases was unknown. Rates of perinatal transmission were relatively low, accounting for 2 percent of total AIDS cases.

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**Estimated Number of Adults and Children Living with HIV/AIDS, end of 2000:** 140,000

**Total Population:** 97 million

**Adult HIV Prevalence:** 0.29%

### **HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 1%

Population at Low Risk: 0.09%

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### ***USAID Strategy***

USAID/Mexico's strategic objective in HIV/AIDS promotes enhanced quality and sustainability of HIV/AIDS and sexually transmitted infection services in target states. USAID/Mexico works with Mexico's National AIDS Program to prepare selected states to assume responsibility for funding, management, and integration of programs to combat HIV/AIDS and sexually transmitted infections. USAID cooperates with the Government of Mexico to target states to 1) assess data and trends in HIV/AIDS and sexually transmitted infections, 2) formulate a strategic plan to address these health issues, and 3) design financially viable programs aimed at prevention and mitigation of HIV/AIDS. Participatory planning and closer linkages between government and civil society are emphasized.

### ***USAID-Supported Country Programs***

USAID, along with UNAIDS, the Ford Foundation, and the Mexican Council for Science and Technology, funds an activity addressing HIV/AIDS prevention for mobile populations in Central America and the United States. A situation analysis will be completed by September 2001 and will form the basis for design of community action in HIV/AIDS prevention in "hot spots" along migrant routes.

The study is being carried out in collaboration with University of North Carolina and Family Health International.

In addition, USAID supports the following projects:

- ⊙ The Futures Group/Policy Project II is working on decentralized strategic planning and resource allocation in selected target states. Work is most advanced in Yucatan, Guerrero, and the State of Mexico. Lobbying efforts and technical assistance were instrumental in establishing a specialized HIV/AIDS clinic in Mexico City, the first of its kind in Mexico, and an HIV/AIDS program for Mexico City, where the largest number of AIDS cases has been reported. Advocacy by planning groups in both Yucatan and Guerrero resulted in an increased line item for HIV/AIDS/STI programs in the 2000 annual state budgets. Yucatan planning group members successfully advocated for state funding for a local laboratory and clinic capable of HIV/AIDS testing and treatment, in accordance with federal guidelines for treatment of HIV-positive patients. In August 2000, the state of Yucatan approved the use of state funds antiretroviral drugs for 10 people living with HIV in the state, which represents a 50 percent increase over the number of people in Yucatan reached by the federally funded program.
- ⊙ The USAID-funded International HIV/AIDS Alliance conducted 15 workshops on training of trainers, institutional strategic planning, external relations, and lessons learned. About 140 nongovernmental organizations participated in the workshops. Organizations from Campeche and Quintana Roo asked to partici-

pate with groups from the neighboring state of Yucatan in Alliance capacity building activities, widening the reach of the program.

- ⊙ A service provision assessment on quality of care in 96 primary care facilities was completed in March 2000, and results were announced at the Seminar on International Cooperation in HIV/AIDS and the Mexican Response. The results will form the basis for targeted improvement and measurement of quality of care in HIV/AIDS and sexually transmitted infections in Secretariat of Health facilities in all target states in 2001–2003. The assessment will yield important data for the national AIDS program and the Secretariat of Health on adherence to national guidelines and standards, and will form the basis for training of health service providers tailored to the needs of each state.
- ⊙ The USAID-funded Family Health International/IMPACT project provides technical assistance to the national AIDS program in developing the first national guidelines for management of sexually transmitted infections. In 2000, Family Health International collaborated with the national AIDS program on a female condom use study. Follow-up technical assistance includes inspecting the data collection and laboratory procedures at the Acapulco and Veracruz sites, and reviewing preliminary data from the Federal District site. The studies will provide data on current treatment and antimicrobial drug resistance to sexually transmitted infections that will inform new diagnosis and treatment protocols included in national guidelines.

## Nicaragua

Nicaragua's first AIDS cases were reported in 1987. Isolation caused by years of civil conflict and an economic embargo imposed by the United States may have contributed to delayed documentation of the epidemic. While prevalence remains low, incidence is increasing among growing numbers of commercial sex workers and a large homosexual and bisexual population. Frequent movement of migrant workers and lack of acceptability of condom use are major contributors to the spread of HIV/AIDS. Nicaraguans residing in areas affected by Hurricane Mitch are at particular risk for HIV infection, and sexually transmitted infections are prevalent in these regions.

HIV/AIDS is centered in Nicaragua's major cities and is overwhelmingly spread by sexual transmission. Heterosexual contact accounts for 65 percent of AIDS cases, while men who have sex with men account for 35 percent. The cities of Managua and Chinandega account for 58 percent of all cases. The Ministry of Health estimated that between 8,100 and 24,000 new HIV infections occurred in 2000, with higher incidence among women. AIDS cases reported to the Ministry of Health total 669. The male-to-female infection rate is 3:1.

### Estimated Number of Adults and Children Living with HIV/AIDS, end of 2000:

4,900

**Total Population:** 5 million

**Adult HIV Prevalence:** 0.2%

### HIV-1 Seroprevalence in Urban Areas:

Population at High Risk: 0.2%

Population at Low Risk: N/A

### USAID Strategy

USAID/Nicaragua's response to HIV/AIDS is multifaceted and still evolving. The Mission's objective is to prevent development of a generalized epidemic in Nicaragua through focused interventions targeting men who have sex with men, commercial sex workers, adolescents, and young adults. Increasing detection and syndromic management of sexually transmitted infections is also a priority, as is expanding condom availability and usage.

In February 2000, the Mission requested an assessment of its HIV/AIDS program, which was conducted through the Synergy Project. Under this assessment, five issues were identified as priorities for the bilateral AIDS Mission program: policy strengthening, data collection and surveillance, diagnosis and treatment of sexually transmitted infections, education campaigns, and condom social marketing. In order to address these issues, USAID/Nicaragua continues to play a strong role in donor coordination and policy dialogue.

### USAID-Supported Country Programs

USAID supports the following activities in Nicaragua:

- ⊙ Providing condoms to the HIV/AIDS Prevention and Control Program of the Ministry of Health.
- ⊙ Providing condoms to nongovernmental organizations through the International Planned Parenthood affiliate, PROFAMILIA. This USAID grantee has been selling "Bodyguard" condoms targeted to youth. From April 2000 to June 2001, more than 1,500,000 Bodyguard condoms were sold, exceeding targets for the first year.
- ⊙ Providing technical assistance to nongovernmental organizations in institutional strengthening (strategic planning, management and adolescent counseling workshops), advocacy, and social marketing through the Development Training Project and the Central American HIV/AIDS Prevention Project.
- ⊙ Implementing a nationwide information, education, and communication campaign through an agreement with Johns Hopkins University.
- ⊙ Managing a \$100,000 subgrant through Johns Hopkins University to Nimehuatzin, a leading nongovernmental organization dedicated to HIV/AIDS prevention. Nimehuatzin will use this grant to launch a targeted program in some of the most affected communities in Chinandega, which has the second highest concentration of HIV/AIDS cases in Nicaragua. Potential interventions to be developed under this grant include providing syndromic management training for Ministry of Health personnel, reducing risky behavior among the trucker population through behavior change communication interventions, organizing community planning groups (Grupos Accion Sida), and increasing access to and demand for condoms.
- ⊙ A subgrant program for \$300,000 will be established in 2001 under the auspices of the USAID-supported NicaSalud nongovernmental organization federation.
- ⊙ Advocating for enactment of Law 238, "Promotion, Protection and Defense of Human Rights in Relation to AIDS," and the National AIDS Strategic Plan.
- ⊙ Developing a behavior change communication strategy based on findings of several recent

studies. The strategy will update policymakers on the current and impending HIV/AIDS situation in Nicaragua and provide a framework within which the Government of Nicaragua, international donors, and the private sector can mobilize resources to implement appropriate interventions.

## Peru

HIV/AIDS in Peru is concentrated primarily in high-risk populations, although women and heterosexual men account for an increasing proportion of cases. According to USAID/Peru, men account for 86 percent of all AIDS cases, and 70 percent of cases occur among those aged 20 to 39. Prevalence among men who have sex with men ranges from 14 percent in Lima to about 5 percent in other major cities. Prevalence among female sex workers residing in Lima ranges from 1 to 3 percent, and national prevalence rates for pregnant women range from 0.3 to 0.5 percent.

Several potential bridging populations are evident in Peru: 35 percent of young Peruvian men reported sexual activity with female sex workers in 1999, and about 20 percent of HIV-positive men who have sex with men report bisexual behavior.

### Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:

48,000

**Total Population:** 25 million

**Adult HIV Prevalence:** 0.35%

### HIV-1 Seroprevalence in Urban Areas:

Population at High Risk: 5%

Population at Low Risk: 0.5%



### *USAID Strategy*

USAID is working to strengthen Peru's National Epidemiological Surveillance System, which tracks sexually transmitted infections and HIV/AIDS, particularly within high-risk groups (i.e., men who have sex with men and sex workers). Mission activities also include strengthening laboratory diagnostic capacity, supporting the study of the relationship between tuberculosis and HIV/AIDS; disseminating information, education, and communication materials; and training peer health educators.

### *USAID-Supported Country Programs*

USAID/Peru works closely with the Programa de Control de Enfermedades de Transmision Sexual y SIDA to curb transmission of sexually transmitted infections, reduce mother-to-child transmission of HIV, ensure a safe blood supply, provide care and support for those affected by HIV/AIDS, and strengthen intersectoral coordination for HIV/AIDS control.

USAID assistance contributed to the establishment of 88 "model health centers" certified by the Ministry of Health in priority regions of the country. The number of couple-years-of-protection provided by the Ministry of Health to family planning users increased from 1.1 million to 1.4 million. The number of people in priority zones trained in key primary health interventions rose to 24,012 in 1999. The number of condoms distributed or purchased through USAID-supported public and private sector channels increased from 38.9 million in 1997 to 46.3 million in 1999 for contraceptive purposes and HIV/AIDS prevention. Ten USAID-supported nongovernmental organizations have started to increase demand and use of health and family planning services in more than 1,000 remote, poor communities.

USAID's support for building sustainable institutions produced important results for both public and private sector health providers.

Project 2000 continued improving the management and quality of care in 12 departments. In 1999, 18 new facilities were certified as in-service health training centers; a total of 88 centers (98 percent of the target) have now been completed and put into operation. Nearly half of the 2,452 health facilities located in 12 Project Regional Directorates have initiated quality improvement programs, largely as a result of in-service training activities offered in Project 2000 training centers. Also, a new budgeting and programming system, based on service delivery costs, was installed in all 34 regional health directorates in the country.

USAID's Repro Salud nongovernmental organization project reaches a large and growing number of women in poor communities with information and activities. Direct beneficiaries for Repro Salud's educational activities grew to 50,000 in 2000.



Photo: UNICEF/Roger Lemoyne

## *Asia and Near East*

Current HIV infection levels in Asia appear small when compared with those in sub-Saharan Africa. However, high population densities, the presence of other sexually transmitted infections and high-risk behaviors, and frequent migration make it likely that Asia will become the pandemic's next epicenter. While adult prevalence levels are less than 1 percent in all but three countries in East, South, and Southeast Asia, an increased prevalence of 0.1 percent in a country such as China or India means that more than 500,000 additional adults will be infected. Many countries in Asia also have high incidence rates of tuberculosis—the leading killer of people infected with HIV.

Until the late 1980s, no country in Asia had reported significant HIV infection levels. In 1992, however, several countries noted increasing numbers of infections concentrated among injecting drug users and commercial sex workers. Thailand was the first to report major infection levels early

in the decade, but with decisive government action, the Thai epidemic was stabilized, and the incidence rate declined beginning in the mid-1990s. UNAIDS estimates that 6.1 million people in Asia are now living with HIV/AIDS (5.6 million adults and children in South and Southeast Asia, and 530,000 in East Asia and the Pacific). The region accounts for about one in five of all HIV-infected adults in the world, with 90 percent of the cases in Asia concentrated in four countries: India (3.7 million cases), Thailand (755,000 cases), Burma (530,000 cases), and China (600,000 cases).

While the epidemic has been present in Asian countries for at least 10 years, sentinel surveillance systems are now in place to monitor the epidemic and behaviors associated with HIV, especially in populations most likely to be affected. At the end of 1999, three countries in Asia had national adult prevalence levels greater than 1 percent: Cambodia (4.04 percent), Thailand (2.15 percent), and Burma

(1.99 percent). Countries with adult prevalence rates between 0.1 percent and 1 percent include India (0.7 percent), Malaysia (0.42 percent), Nepal (0.29 percent), Vietnam (0.24 percent), Papua New Guinea (0.22 percent), and Pakistan (0.10 percent). A closer look at India's epidemic reveals that it is concentrated in the south, west, and northeastern states with adult prevalence rates of 1–2 percent or greater. Infection levels are less than 0.1 percent in most other Asian nations, including China, the Philippines, and Sri Lanka (each at 0.07 percent); Indonesia and Lao (both at 0.05 percent); and Bangladesh (0.02 percent).

The HIV/AIDS epidemic in Asia is diverse and variable, with the most rapid transmission occurring in South and Southeast Asia. Injecting drug users and commercial sex workers remain the principal transmitters of HIV, and these groups also serve as a bridge to the general population.

## Commercial Sex Workers and Condom Use

The commercial sex industry in Asia continues to thrive and has resulted in HIV levels of 10 percent or higher among sex workers in Burma, Cambodia, Nepal, Papua New Guinea, and Thailand. Recently, several countries such as Cambodia, India (in Tamil Nadu), Lao, Nepal, the Philippines, and Thailand have been successful in increasing condom use by sex workers and their clients. In the Philippines, registered sex workers are also screened biweekly for sexually transmitted infections. However, rates of sexually transmitted infections have increased markedly in recent years along China's eastern seaboard, signaling a lack of condom use and the potential for rapid spread of HIV to other regions. China has an estimated 4 million sex workers, and surveys show that more than half have never used a condom to protect themselves from HIV or sexually transmitted infections. Among men who interact with commercial sex workers in Vietnam, condom use is very low.

## Injecting Drug Use

HIV prevalence among injecting drug users has become alarmingly high in Asia. For example,

70 percent of injecting drug users in urban areas of Burma are now HIV positive; in Nepal and Vietnam, 40 to 50 percent and 18 percent of injecting drug users, respectively, are HIV-positive. In northeastern India, HIV infection has now moved from male injecting drug users to their wives.

## Migration

The spread of HIV in Asia is being facilitated by high levels of national and international migration. In many instances, mobile populations are more susceptible to HIV infection because of risk factors associated with their occupation, social status, or economic situation. For example, 50 percent of Nepali women who have served as sex workers in Mumbai, India, are HIV-positive; among Nepali sex workers who worked in other Indian cities, HIV prevalence is 17 percent.

Some experts refuse to be complacent about the prospect of AIDS in Asia. Home to 60 percent of the global population, the region could fast become the world's most HIV/AIDS-affected region. In fact, some predict that the number of AIDS cases in Asia will surpass those found in sub-Saharan Africa by 2010, and estimate that currently, India alone has more than 10 million infected individuals. HIV levels in several Asian countries could escalate in the future unless measures are taken to protect sex workers and their clients through screening for sexually transmitted infections and condom use, as is done in Thailand and the Philippines. Behavior change interventions for injecting drug users are also needed to slow the spread of HIV. If the epidemic escalates, particularly in China or India, the overall impact on the region will be significant.

In the Near East, HIV infection levels remain relatively low (fewer than 0.1 percent of adults). The World Health Organization reports about 220,000 HIV cases in the region. In Egypt, Morocco, and Tunisia, there is evidence of mini-epidemics and increased numbers of injecting drug users. Limited surveillance and reporting of HIV/AIDS cases remain a problem in most Near Eastern countries.



## Regional Initiatives

Since 1993, USAID has supported HIV/AIDS activities in 13 countries in Asia and the Near East. In addition to USAID Mission programs, regional HIV activities have also been supported by the Asia and Near East regional HIV program in Bangladesh, Cambodia, India, Indonesia, Lao, Morocco, Nepal, the Philippines, Sri Lanka, Thailand, and Vietnam. The regional program targets mobile populations, cross-border transmission, and the spread of HIV into low prevalence countries by working with local governments, non-governmental organizations, and communities to:

- ⊙ Limit cross-border HIV transmission,

- ⊙ Prevent HIV transmission in USAID nonpresence countries through education and condom promotion,
- ⊙ Strengthen surveillance capacity and HIV policy,
- ⊙ Expand regional training and human capacity, and
- ⊙ Develop and disseminate new models for prevention and care and support.

In 2000, the regional program was expanded to include other infectious diseases such as tuberculosis and malaria. As a result, efforts will be made to strengthen surveillance of tuberculosis/HIV co-infections and develop appropriate interventions to address the dual epidemics.

## Bangladesh

At the end of 1999, an estimated 13,000 Bangladeshis were living with HIV/AIDS. Studies have found HIV prevalence at 0.3 percent among female sex workers in major urban areas, 0.2 percent among male patients with sexually transmitted infections, and 2.5 percent among injecting drug users.

Without significant behavior change and HIV/AIDS information dissemination, HIV could quickly spread among high-risk groups, including sex workers and their clients, migrants, and injecting drug users.

Several factors put Bangladesh at risk for the spread of HIV:

- ⊙ Low use of condoms among high-risk groups (e.g., female, male, and transgender sex workers, men who have sex with men, and migrant populations);
- ⊙ Significant prevalence of sexually transmitted infections among sex workers in Dhaka (according to a 1999–2000 study, 23 percent of injecting drug users, 33 percent of brothel sex workers, 43 percent of street-based sex workers, and 13 percent of men who have sex with men tested positive for syphilis);
- ⊙ An unsafe blood supply and low awareness among the general population of the dangers of HIV and sexually transmitted infections; and
- ⊙ Contact through shared borders via sea and land routes with India and Myanmar, which have higher HIV prevalence.

**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 13,000

**Total Population:** 127 million

**Adult HIV Prevalence:** 0.02%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 0.6%

Population at Low Risk: N/A

### USAID Strategy

USAID/Bangladesh is one of the largest donors to the HIV/AIDS sector. Support includes control of HIV through a social marketing program; peer education, condom promotion, and sexually transmitted infection prevention and care services targeted at high-risk populations; information, education, and communication efforts geared toward high-risk groups; and surveillance and operations research.

### USAID-Supported Programs

In August 2000, Family Health International began implementing activities under the IMPACT project. The project aims to reorient existing services and introduce new services for vulnerable populations such as sex workers, men who have sex with men, and injecting drug users, as well as strengthen national HIV/AIDS surveillance activities.

Currently, Family Health International/IMPACT is assisting the Urban Family Health Partnership and the Social Marketing Company to target at-risk groups by providing technical assistance in preventing sexually transmitted infections, and promoting behavior change communication and social marketing activities for HIV prevention.

Other Family Health International/IMPACT activities include:

- ⊙ Implementation of full clinical

and behavioral HIV prevention services in three cities for men who have sex with men, as well as education for this population and their health providers;

- ⊙ Development of an intervention that effectively targets hotel managers, hotel boys, sex workers and their clients on the basis of a hotel-based sex worker study and hotel mapping assessment;
- ⊙ Promotion of self-run sex worker HIV prevention projects;
- ⊙ A prevention needs assessment for injecting drug users and heroin users, followed by a policy and planning workshop on drug use and HIV prevention;
- ⊙ Development of a monitoring tool for the national AIDS program to assess overlap and gaps in HIV/AIDS interventions;
- ⊙ The third round of the national behavioral surveillance survey; and
- ⊙ An assessment of causes of high condom breakage rates in high-risk groups.

### *HIV/AIDS prevention and control awareness campaigns*

The Urban Family Health Partnership; the social marketing company, Bandu; and the International HIV/AIDS Alliance provide orientation and peer education to high-risk people throughout Bangladesh. Target populations include sex workers and their clients, men who have sex with men, truckers, and rickshaw pullers.

### *Condom distribution and social marketing*

The Family Planning Logistics Management Project provides technical support to the government to ensure that condoms are regularly and efficiently distributed throughout Bangladesh. The social marketing company distributes condoms and implements peer education programs in high-risk areas to promote safe sex and

condom use.

### ***Sexually transmitted infection control***

The Urban Family Health Partnership provides clinic-based treatment services for sexually transmitted infections, and implements HIV/AIDS counseling, peer education support, and general awareness activities.

### ***Research***

The social marketing company conducts research to test the feasibility of providing prepackaged female condoms to high-risk populations and treatments for syndromic sexually transmitted infections. The International Centre for Diarrhoeal Diseases Research has conducted research on sexually transmitted infection syndromic approaches in urban and rural clinics, antenatal screening for syphilis, and training assessments of syndromic management.

## **Cambodia**

Cambodia's HIV/AIDS epidemic is one of the fastest growing in Asia. The epidemic was initially concentrated in high-risk segments of the population but has now reached the general population. Surveillance data suggest a high prevalence and indicate that the majority of HIV-infected Cambodians are not aware of their serostatus. The highest rates of infection have been found in the southeast and central provinces, and along the Thai border.

Statistics released in May 2001 by the Ministry of Health revealed that the spread of HIV/AIDS has slowed in Cambodia. Surveillance data show 169,000 HIV-infected adults (aged 15–49) nationwide, yielding a 2.8 percent infection rate among that age group. This number represents a significant

decline from 1997 estimates, which had put adult HIV infections at 210,000 (3.9 percent of all adults).

Heterosexual contact is the major mode of HIV transmission in Cambodia. In 1999, HIV prevalence among female sex workers ranged from 7.3 percent to 52.0 percent. However, new infections among sex workers under age 20 dropped from more than 40 percent in 1998 to 23 percent in 2000. Surveys conducted in 1998 indicate that overall condom use among men with sex workers was between 53 percent and 63 percent, compared with only 5 percent to 24 percent with regular or non-sex-worker partners.

UNAIDS estimates that at the end of 1999, 13,000 Cambodian children had become orphans due to AIDS since the beginning of the epidemic.

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**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 169,000

**Total Population:** 10.9 million

**Adult HIV Prevalence:** 2.8%

**HIV-1 Seroprevalence in Urban Areas:**  
Population at High Risk: 61.3%  
Population at Low Risk: 3.8%

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### ***USAID Strategy***

USAID focuses its prevention and control efforts on high-risk populations and on individuals who form bridges between high-risk groups and the general population. Current activities have three goals: to better inform policymakers about the HIV/AIDS epidemic, to reduce high-risk behaviors in target areas, and to pilot and replicate sexually transmitted infection and health care services for high-risk populations.

### ***USAID-Supported Programs***

USAID supports efforts to reduce transmission of HIV and other sexually transmitted infections primarily among sex workers and their clients. Activities include promoting condom use in brothels, increasing participation of religious leaders in prevention and care, strengthening the network of non-governmental organizations, developing behavior change intervention programs for high-risk men and women, and developing sexually transmitted infection prevention and care facilities for sex workers and their clients.

### ***Condom distribution and social marketing***

Since 1993, Population Services International has played an important role in implementing a nationwide condom distribution program. Through its social marketing program, more than 56.3 million condoms have been sold, with sales increasing every year. Currently, condoms are reported to be available in more than 90 percent of commercial sex establishments.

### ***Behavior change communication***

Population Services International/IMPACT has implemented a highly effective information, communication, and education program to raise awareness among the general population of the dangers of HIV/AIDS and sexually transmitted infections.

Family Health International and the International HIV/AIDS Alliance initiated new activities to address the needs of children affected by HIV/AIDS, including orphans. Family Health International provides education and care services to sexually active street children, and works to educate their families on ways to prevent HIV transmission. The Alliance has supported the establishment of the Khmer HIV/AIDS Nongovernmental Organization Alliance, which strengthens the work of organizations involved in HIV/AIDS



efforts, encourages new groups to become more involved, and encourages cooperation to identify funding and technical support. The Alliance is also building the capacity of local organizations to provide home care and support teams for people living with HIV/AIDS.

#### **Operations research**

The Population Council's Horizons Program is conducting research on the effect of prevention behaviors, provision of home care to persons living with HIV/AIDS, and community mobilization approaches to decreasing HIV transmission in sex work.

USAID also supports the Border Area HIV/AIDS Project, which is implemented by CARE International. The project conducts research and provides cross-border prevention and care services for people with HIV/AIDS and sexually transmitted infections in Koh Kong Province.

## **Egypt**

The HIV/AIDS epidemic appears to be at an early stage in Egypt. Limited available data indicate that HIV cases have been reported in the general population, as well as in vulnerable groups such as commercial sex workers, the large hidden community of men who have sex with men, and injecting drug users. The strong influence of the Islamic and Coptic moral codes, which forbids adultery, sex before marriage, and other practices, may be an important factor in discouraging high-risk sexual behavior and limiting the spread of HIV/AIDS.

By the end of 1999, an estimated 8,100 adults and children were living with HIV/AIDS, but due to gaps in diagnosis, underreporting, and reporting delays, officially reported cases represent only a portion of all cases. Adult preva-

lence is estimated to be 0.02 percent. There are no estimates on the number of deaths due to AIDS or AIDS orphans.

The Ministry of Health and Population implements an HIV/AIDS control program. Its HIV/AIDS hotline, which was developed with a grant from the Ford Foundation, is considered to be one of the most innovative HIV/AIDS prevention activities in the region.

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<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>	8,100
<b>Total Population:</b>	67.2 million
<b>Adult HIV Prevalence:</b>	0.02%
<b>HIV-1 Seroprevalence in Urban Areas:</b>	
Population at High Risk:	N/A
Population at Low Risk:	N/A

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#### **USAID Strategy**

USAID/Egypt has assisted the Egyptian Ministry of Health and Population by providing technical assistance primarily in the areas of operations research and training. In collaboration with Family Health International/IMPACT, USAID supported a sexually transmitted infection prevalence study, as well as technical assistance to improve blood safety. With the development of a new strategic objective (2001), the Mission's focus will shift toward approaches that enhance the sustainability of programs to combat HIV and sexually transmitted infections. These approaches include close collaboration with Egyptian partners at all stages of design, planning, implementation, and monitoring and evaluation; working with established organizations and strengthening their capacity to carry out

the programs; and investing in the development of sustainable systems and skills of Egyptian partners.

#### **USAID-Funded Programs**

An assessment of the effect of HIV/AIDS in Egypt was first conducted in 1996. Since that time, a number of small but significant activities have taken place. Recently, USAID funded a prevalence study of sexually transmitted infections in Egypt. This study, conducted by the Ministry of Health and Population and Family Health International/IMPACT, provides an increased understanding of the prevalence of sexually transmitted infections in high-risk populations—sex workers, injecting drug users and men who have sex with men, and in the general population through family planning and antenatal clinics.

Results and recommendations from this study will be disseminated in partnership with the Ministry of Health and Population to policy and program-level stakeholders. Information gleaned from this study will be useful in the subsequent design and implementation of culturally appropriate comprehensive HIV prevention activities.

Because there is little understanding of risk behaviors in bridge populations (port workers, transport workers, seasonal laborers, and Ministry of Interior urban workers) and among youth, USAID will work with key stakeholders to design and implement behavioral data collection in these groups.

Since 1999, USAID, through Family Health International/IMPACT, has worked to build capacity within the National Blood Transfusion Service in the areas of donor recruitment and retention. This assistance is designed to establish a sustainable, voluntary, community-oriented blood donor base. Currently, basic blood bank training with emphasis on safe blood donation is being conducted

for blood bank staff. A communication and training guide that targets service providers and highlights universal blood precautions will be issued in 2001. A pilot donor recruitment and recall strategy is currently being implemented in Alexandria, where a regional blood center is located.

Family Health International/IMPACT has also assisted in introducing the concept of universal precautions within blood banks. Technical assistance is being provided to the Universal Precautions Committee.

USAID's Nongovernmental Service Center in Cairo will provide technical assistance, training, and small grants to Egyptian nongovernmental organizations working in HIV/AIDS prevention and mitigation.

## India

India is home to the largest number of people infected with HIV in Asia. An estimated 3.9 million Indians are living with HIV/AIDS, with an adult prevalence rate of 0.7 percent. Sentinel surveillance studies conducted in 1999 found HIV seroprevalence of greater than 1 percent in six of 32 states and territories. The epidemic is growing outside high-risk groups and is now found in the general population. It is also moving from urban to rural districts.

As of July 2001, 24,680 AIDS cases had been reported to the Ministry of Health, although this is believed to be an underestimate. HIV prevalence among pregnant women varies throughout the country, ranging from 0 percent to 2.6 percent.

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**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 3.9 million

**Total Population:** 1 billion

**Adult HIV Prevalence:** 0.7%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 0.8%

Population at Low Risk: 0.3%

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### USAID Strategy

USAID/India's strategy is to focus on prevention so that HIV/AIDS can be contained. Prevention activities focus on high-risk populations such as sex workers and truck drivers, who are likely core transmitters of HIV. However, USAID/India is also working to build awareness in low-risk rural populations and will endeavor to promote prevention activities through health services outreach projects. USAID assistance is focused in Tamil Nadu and Maharashtra, states with prevalence rates greater than 1 percent. USAID has developed a partnership approach with the Government of India, nongovernmental organizations, businesses, and others to fight HIV. Emphasis is being placed on community-based and work-based approaches to controlling the epidemic.

### USAID-Supported Programs

USAID is one of the largest donors to HIV/AIDS prevention and control activities in India. In 1995, USAID began supporting the first state-specific intervention program, the AIDS Prevention and Control Project, in Tamil Nadu. This 10-year, \$10 million project supports nongovernmental organizations in designing and implementing community-based prevention programs that target high-risk populations such as sex workers and their clients, patients with sexually trans-

mitted infections, slum dwellers, and truckers and their helpers. The project emphasizes preventive behavior through peer education, the promotion and sale of condoms, and improved treatment of sexually transmitted infections. Annual HIV risk behavioral surveillance surveys track key behavior changes such as condom use, sexually transmitted infection treatment-seeking, and decreases in sexual contacts with nonregular partners. These surveys, plus seroprevalence surveillance data, show positive trends in risk avoidance behavior and in decreased prevalence levels.

In 1999, USAID expanded HIV/AIDS prevention activities to Maharashtra State. The seven-year, \$41 million project, called AVERT, supports a prevention effort in urban and periurban areas, increases the role of nongovernmental organizations in HIV prevention, and explores models of care and support for HIV-infected individuals. USAID also supports projects that address children affected by HIV/AIDS in Delhi, Tamil Nadu, Maharashtra, and elsewhere.

In addition, USAID supports the National AIDS Control Organization by providing financial and technical assistance to national programs. USAID also supports the Program for Advancement of Commercial Technology/Child and Reproductive Health, which provides financial support and technical assistance to the commercial sector to expand condom distribution. The program is assisting the Drug Controller of India to strengthen quality control and monitoring activities, and is working with manufacturers to improve condom packaging. The program also supports the private and commercial sectors in creating new diagnostic products and improving the quality and marketing of existing products.

Future efforts may include integrating HIV prevention with the

Mission's Reproductive Health Program in Uttar Pradesh; expanding the social marketing of condoms; supporting a network of nongovernmental organizations to add HIV prevention, care, and support services to their existing programs; and supporting the National AIDS Control Organization to increase HIV awareness and to treat sexually transmitted infections at the community level.

## Indonesia

Indonesia stands at a crossroads in the transmission of HIV. Concentrated pockets of HIV are now appearing in defined population groups in Irian Jaya Province and port cities throughout the Indonesian Archipelago. While the nation's overall HIV adult prevalence rate remains at less than 0.1 percent, a rapidly emerging HIV epidemic is occurring among women and men at high risk for infection.

Only five years ago, HIV prevalence was estimated to be less than 1 percent in traditional high-risk groups, including sex workers, men who have sex with men, and injecting drug users. With each new surveillance cycle, more provinces are demonstrating rising infection rates in these groups. HIV prevalence among injecting drug users had increased from less than 2 percent in 1998 to 44 percent in Jakarta and 24 percent in West Java by 2000. In Bali, HIV infection rates for injecting drug users reached 53 percent in early 2001. Among female sex workers, HIV prevalence ranges from 8 percent in Tanjung Batu in Riau Province to 26.5 percent in the Irian Jaya port city of Merauke. Although data for men who have sex with men are limited, both Jakarta and Riau Provinces have reported that more than 6 percent of transvestites (Waria) are HIV-infected.

Based on changing HIV prevalence and revised population estimates, the Ministry of Health and Social Welfare estimated that as of mid-2001, there were 120,000 HIV-infected individuals nationwide. Using UNAIDS guidelines, the epidemic in Indonesia has been reclassified from a low-level epidemic to a concentrated one, due to recent and dramatic rises in HIV prevalence among high-risk groups.

Condom use remains low during most commercial sex encounters. High rates of sexually transmitted infections among high-risk populations suggest that HIV may readily spread among individuals not using condoms. In Jakarta, rates of sexually transmitted infections among female sex workers increased from 23 percent in 1996 to 53 percent in 2000. Syphilis prevalence among Waria in Jakarta is estimated at 44 percent, up from 35 percent in 1995.

<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>	120,000
<b>Total Population:</b>	203 million
<b>Adult HIV Prevalence:</b>	<1%
<b>HIV-1 Seroprevalence in Urban Areas:</b>	
Population at High Risk:	18%
Population at Low Risk:	N/A

### USAID Strategy

USAID's technical strategy is to support prevention interventions and improve surveillance among key population groups at geographic sites in order to reduce risk behaviors and infection rates. This is in concert with the Government of Indonesia's national prevention strategy for HIV and other sexually transmitted infections. The goal is to keep HIV prevalence low in high-risk populations, thereby pre-

venting and delaying the spread of HIV throughout the Indonesian Archipelago.

### USAID-Supported Programs

The HIV/AIDS Prevention Project ended in September 2000. Key project achievements included the development of behavioral surveillance systems, the testing of prevention strategies and innovative outreach education initiatives to high-risk population groups, new condom marketing strategies, and increased participation in planning for HIV/AIDS and other sexually transmitted infections by government officials.

In August 2000, USAID/Indonesia awarded a three-year, \$13.9 million cooperative agreement to Family Health International/IMPACT to implement the STI/HIV/AIDS Prevention Support Program in collaboration with the Ministry of Health and Social Welfare, provincial and district governments, and local organizations. Known locally as "ASA" or "Aksi-STOP AIDS," the program supports intensive prevention interventions among female sex workers, men who have sex with men, injecting drug users, and the sex worker-client bridge population.

The program also has partnerships with local governments and community and private organizations to strengthen Indonesia's surveillance systems and to plan, manage, and finance appropriate HIV and sexually transmitted infection responses at the local level. To maximize the use of limited resources available for HIV/AIDS in Indonesia, the program works in 10 communities in which a high density of specified population groups reside, or where epidemiological and behavioral evidence suggests that the epidemic is escalating. These high-risk communities include Irian Jaya, metropolitan Jakarta, East Java (Surabaya), North Sulawesi (Manado/Bitung),



the Riau Islands, Central Java (Semarang), West Java (Bandung), South Sumatra (Palembang), North Sumatra (Medan), and the Maluku.

## Lao People's Democratic Republic

Lao People's Democratic Republic is still a low prevalence country, with an infection rate of about 0.05 percent among men and women aged 15–24. However, the country is bordered by Cambodia and Thailand—home to the highest rates of HIV in Asia—and by China and Vietnam, where HIV infection rates have been rising rapidly. Systematic nationwide surveillance activities for HIV and other infectious diseases are not yet in place, resulting in considerable uncertainty about the course of the epidemic in Lao. The first AIDS case was reported in 1991. According to UNAIDS, 1,400 Laotians were living with HIV/AIDS in 1999, and 130 had died of AIDS. As of 2000, women accounted for 52 percent of adult HIV infections.

### Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:

1,400

**Total Population:** 5.3 million

**Adult HIV Prevalence:** 0.05%

### HIV-1 Seroprevalence in Urban Areas:

Population at High Risk: N/A

Population at Low Risk: 0.4%

### USAID Strategy

USAID does not have a Mission in Lao Peoples Democratic Republic, but it funds activities through the Asia and Near East Bureau's Regional Program, implemented by Family Health International/IMPACT. Condom promotion and social marketing programs by Population Services International/AIDSMark have promoted information and access to affordable condoms, and Family Health International/IMPACT has collaborated with the Lao National Committee for the Control of AIDS to conduct surveillance activities. These partnerships assure that national and local organizations have the motivation and skills to undertake future surveillance work. Four "twin city" pairs of cross-border surveillance sites were established in 1998 between Thailand, Cambodia, Lao, and Vietnam.

Results released from a new USAID-funded survey conducted by Family Health International show that although many men have multiple sexual partners, condom use is high. The survey includes responses from several thousand men and women who were interviewed about their sexual partnerships and condom use. Behavioral surveillance was conducted in five provinces among seven population groups that are most likely to be at risk for HIV. Among the positive findings of the survey were the high levels of reported condom use in commercial sex transactions. Nearly three-quarters of female sex workers reported they always use condoms with a paid partner. These condom use levels parallel those reached by neighboring countries after many years of aggressive HIV prevention efforts. Lao Peoples Democratic Republic had achieved a high level of condom use in risky sexual behavior before the epidemic took hold.

Television commercials and puppet shows have also been created to promote condom use and responsible sexual behavior, and public education efforts were conducted during World AIDS Day activities.

Additional activities include capacity building for mass media HIV/AIDS campaigns in collaboration with the United Nations Children's Fund.

## Nepal

Although available data indicate that HIV prevalence remains relatively low in Nepal, an active sex trade, high rates of trafficking of girls and women to India for sex work, increasing numbers of injecting drug users, and seasonal and long-term labor migration place the nation at high risk for a burgeoning epidemic.

The first cases of AIDS in Nepal were reported in 1988. Surveillance data are scarce but indicate that HIV prevalence currently rests at 0.29 percent of the adult population. As of September 1999, 265 cases of AIDS and more than 1,000 HIV infections had been reported to the Ministry of Health. It is likely that the actual number of cases is many times higher. UNAIDS estimates that in 1999, 34,000 adults and children were living with HIV/AIDS, and an estimated 2,500 people had died from AIDS.

Kathmandu has the highest incidence of HIV infection. The primary mode of HIV transmission in Nepal is through heterosexual contact, but infection rates among injecting drug users have risen rapidly over the last few years. HIV prevalence among injecting drug users increased from 2.2 percent in 1995–1996 to almost 50 percent in 1997–1998.

At the end of 1999, an estimated 930 children under the age of 15

were living with HIV/AIDS, and 2,500 had become orphans due to AIDS.

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<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>		34,000
<b>Total Population:</b>	23.4 million	
<b>Adult HIV Prevalence:</b>		0.29%
<b>HIV-1 Seroprevalence in Urban Areas:</b>		
Population at High Risk:	16%	
Population at Low Risk:	N/A	

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#### *USAID Strategy*

USAID's HIV/AIDS strategy in Nepal seeks to increase awareness and use of HIV and sexually transmitted infection prevention and control services through effective communications and counseling. In 1998, the program expanded into new districts along truck routes and border areas. Cross-border collaboration serves as a regional model, resulting in better and more effective joint prevention and control activities.

USAID activities in the region include condom social marketing, cross-border prevention activities, capacity building for local authorities and nongovernmental organizations to undertake surveillance and reporting on HIV/AIDS in high-risk areas, behavior change surveys, improved management of sexually transmitted infections, and support for improved national policy.

#### *USAID-Supported Programs*

USAID supports Family Health International/IMPACT and its efforts to reduce the sexual transmission of HIV. Activities target sex workers and their clients; women and men with multiple partners; wives with transient husbands; injecting drug users in Kathmandu Valley; and adolescents.

The Population Council's HORIZONS program is conducting operations research on the trafficking of girls and women for sex work and on the care and support of HIV/AIDS-affected persons.

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## Philippines

The Philippines has thus far had a low incident rate of HIV/AIDS. The national HIV sentinel surveillance system indicates that seroprevalence remains below 3 percent among registered female sex workers. While the Philippines has been successful in keeping the AIDS epidemic at bay, an active sex industry and a sizable population of injecting drug users pose a threat for a future spread of the disease. The Government of the Philippines, with USAID assistance, is implementing a program aimed at 1) controlling transmission of HIV and other sexually transmitted infections among target populations through focused education programs that encourage behavior change, and 2) institutionalizing HIV sentinel and behavioral surveillance systems to monitor HIV prevalence and high-risk behaviors.

The Philippine Department of Health monitors the HIV/AIDS epidemic through 10 sentinel sites. It conducts annual surveys among high-risk population groups, including male and female sex workers, men who have sex with men, male patients with sexually transmitted infections, and injecting drug users. All sentinel sites have reported low rates of HIV prevalence (less than 1 percent in high-risk groups). Behavioral data from 1997–2000 show increasing knowledge of AIDS and prevention practices among the population, although high levels of risk behavior continue.

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<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>		10,000
<b>Total Population:</b>	76.5 million	
<b>Adult HIV Prevalence:</b>		0.06%
<b>HIV-1 Seroprevalence in Urban Areas:</b>		
Population at High Risk:	N/A	
Population at Low Risk:	N/A	

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#### *USAID Strategy*

USAID is working with governmental and nongovernmental organizations to monitor HIV transmission and track risk behaviors among target population groups, to develop and implement effective communication and behavior change programs to maintain low rates of infection, and to establish model sites for management and care of individuals with sexually transmitted infections. With USAID support, the Government of the Philippines and several nongovernmental organizations are developing a set of interventions at selected sites. USAID also supports analysis, dissemination, and implementation of advocacy efforts to promote prevention of HIV and sexually transmitted infections.

#### *USAID-Supported Programs*

USAID's AIDS Surveillance and Education Project is a multiyear project (1992–2002) that channels support to the national AIDS program for surveillance, prevention, and education activities.

The World Health Organization Western Pacific Regional Office supports the Department of Health's HIV sentinel surveillance and behavioral sentinel surveillance systems, which are providing systematic early warning data on increasing HIV infection rates and risk behaviors among high-risk groups.

The Program for Appropriate Technology in Health implements the education and behavior change components of USAID's AIDS Surveillance and Education Project. Implemented through local nongovernmental organizations, training activities have focused on project and financial management; behavioral research; media materials development; community outreach and peer education among high-risk groups; sexually transmitted infection prevention and syndromic management; condom distribution; and project reporting, monitoring, and evaluation. Client groups include female and male sex workers, male clients of female sex workers, men who have sex with men, injecting drug users, and sexually exploited children. Ongoing USAID assistance is focused on strengthening the capability of local governments to fund and manage activities to maintain the low prevalence of HIV/AIDS in their communities.

The Family Health International/IMPACT project addresses gaps in USAID's AIDS Surveillance and Education Project, especially in understanding the cultural context of sexually transmitted infections and how to refine the prevention response to accelerate efforts made thus far.

The International HIV/AIDS Alliance is working to link nongovernmental organizations to enhance their skills in behavior change communications and best practices. The Alliance works through the Philippine HIV/AIDS Nongovernmental Organization Support Program with projects designed to increase the role of the organization in policy and advocacy, and to involve youth and other community members in activities to help them reduce their vulnerability to HIV.

## Thailand

The first cases of AIDS in Thailand were detected in 1984 among men who have sex with men. By 1988, the disease had spread to injecting drug users and to sex workers and their clients. HIV infection has since extended beyond high-risk behavior groups and into the general population. Heterosexual transmission now accounts for more than 80 percent of new HIV infections. HIV has been detected nationwide, with the greatest concentration of infections appearing in the Upper Northern region.

UNAIDS estimates that in 1999, 740,000 adults aged 15–49 were living with HIV/AIDS, representing 2.15 percent of the adult population. In addition, 12,900 children under the age of 15 were living with HIV/AIDS, and 75,000 children had become orphans due to AIDS since the beginning of the epidemic.

Mother-to-child HIV transmission continues to contribute to a significant number of new HIV infections, regardless of the availability of antiretroviral therapies from the government.

Following the Asian economic crisis of 1998, school enrollment in Thailand declined, thereby reducing opportunities to reach children and youth with HIV/AIDS education. Economic hardship, especially in the northern provinces, promotes trafficking in women and children into the sex industry. Estimates of the number of children involved in sex work in Thailand range from 13,000 to more than 100,000.

HIV prevalence trends have shown a stabilization or decline in recent years, indicating positive results of an aggressive national response to the epidemic. The decrease in HIV prevalence is attributed to an

increase in condom use among sex workers and their clients, a decline in the frequency of visits to sex workers, and a decline in the prevalence of sexually transmitted infections. Aggressive information and education campaigns, a national 100 Percent Condom Program for sex establishments, and countrywide condom distribution have also played a role in the transmission decline.

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**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 755,000

**Total Population:** 60.8 million

**Adult HIV Prevalence:** 2.15%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 19.1%

Population at Low Risk: 2.4%

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### USAID-Supported Programs

Since the closure of its Mission in Thailand in 1997, USAID has worked through Thai institutions and experts to train regional staff in HIV/AIDS prevention. In addition, with funding from USAID's Asia Near East Bureau, Family Health International/IMPACT is enhancing the capacity of Thai agencies to provide care and support services to people living with HIV/AIDS, harm reduction for injection drug users, and awareness and prevention activities along the Thai–Cambodian border.

USAID funds the Population Council's Horizons program, which is conducting research in a number of areas, including secondary analysis of data on reproductive tract infections, programming for HIV prevention in schools, evaluation and accreditation of workplace AIDS programs, and case management of oppor-



tunistic infections. The program is also holding regional workshops to integrate HIV/AIDS information into family planning and health care programs.

USAID supports the International HIV/AIDS Alliance in its work to link together experienced non-governmental organizations to implement HIV prevention, care, and support activities, and to enhance or expand their capacity to undertake these activities.

## Vietnam

The incidence of HIV/AIDS in Vietnam is growing rapidly as economic development and transportation links increase mobility within and between countries of the Mekong region of Southeast Asia. The first case of HIV infection in Vietnam was reported in 1990. Since then, more than 20,000 HIV cases have been reported in all 61 provinces.

UNAIDS estimates that HIV prevalence in Vietnam is low (0.24 percent of adults), but it could be as high as 65 percent among injecting drug users. At the end of 1999, 100,000 people were living with HIV/AIDS, 2,500 of whom were children. In 1999 alone, UNAIDS estimates that 2,500 people died from AIDS and that 20 percent of HIV/AIDS cases occurred among women aged 15–49. An estimated 3,200 children under 15 years old have lost their mother or both parents to AIDS since the beginning of the epidemic.

Information, education, and communication efforts through mass media have targeted those with high-risk behaviors. HIV/AIDS education programs are included in school curricula in grades 5, 9, 11, and at university.

<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>	<b>100,000</b>
<b>Total Population:</b>	<b>78.6 million</b>
<b>Adult HIV Prevalence:</b>	<b>0.24%</b>
<b>HIV-1 Seroprevalence in Urban Areas:</b>	
Population at High Risk:	4.9%–26.9%
Population at Low Risk:	0.2%

### USAID Strategy

USAID does not have a Mission in Vietnam, but HIV/AIDS activities are currently taking place under Family Health International's IMPACT project, funded by the Asia/Near East Bureau. Regional initiatives in counseling and cross-border activities are also underway.

### USAID-Supported Country Programs

Family Health International established a country office in Hanoi in 1999 and began implementing activities in December of that year, funded by the Asia and Near East Bureau's Regional HIV program. The program has begun work in four provinces and focuses on

- ⊙ Behavioral surveillance surveys designed to understand the degree and kinds of risk behaviors occurring;
- ⊙ Situational analyses to focus interventions on vulnerable groups;
- ⊙ Capacity building for provincial AIDS committees;
- ⊙ Condom social marketing in six provinces (40 million condoms were sold in 1999 through a subagreement with DKT, a social marketing nongovernmental organization);
- ⊙ Establishment of new drop-in centers for intravenous drug users;

- ⊙ Peer counseling training for sex workers;
- ⊙ An upgrade of the skills of health care providers to appropriately diagnose and treat sexually transmitted infections;
- ⊙ A women's health club for sex workers;
- ⊙ Behavior change communication to support men in changing their sexual behavior;
- ⊙ An upgrade of diagnostic and treatment skills of private practitioners and pharmacists to treat sexually transmitted infections;
- ⊙ Staff and peer communication training in re-education centers;
- ⊙ Intensive behavior change outreach to high-risk groups (sex workers, their clients and injecting drug users) to reduce transmission rates of HIV and other sexually transmitted infections; and
- ⊙ An intensive campaign to raise awareness of men's sexual health needs.

Even though approximately 40 million condoms were distributed through DKT, a major shortage exists because of lack of donor money.



Photo: Curt Carnemark/World Bank

## *Europe and Eurasia*

Until 1995, the Europe and Eurasia region was largely unaffected by HIV/AIDS, with an estimated total of 30,000 infections. This figure increased more than five-fold between 1995 and 1997, with a 56 percent rise in new infections. Russia and Ukraine experienced the most dramatic increases, with Belarus, Moldova, and Kazakhstan not far behind. In just three years, the cumulative number of HIV cases tripled in the countries bordering the eastern Baltic Sea region, demonstrating that the epidemic has rapidly gained a foothold in an area previously characterized by low HIV prevalence.

As of late 1999, an estimated 420,000 people in the region were infected with HIV. By the end of December 2000, this figure escalated to 700,000 individuals (primarily male injecting drug users). UNAIDS documented a total of 14,000 HIV-related deaths for 2000. Currently, the overall adult prevalence is 0.35 percent, but rises as high as 0.96 percent in Ukraine. Close comparison of HIV

prevalence levels reveals that Ukraine, Russia, Belarus, and Moldova rank highest in the region, even in comparison to regional prevalences for Central Asia, the Baltics, and Central and Southeastern Europe.

Despite these differences in HIV/AIDS prevalence, the countries of the Europe and Eurasia region share remarkably common characteristics that include:

- ⊙ Little reliable data about the magnitude, location, and progress of the epidemic;
- ⊙ Low level of awareness among decisionmakers and the general public about the disease and its potential impact upon economies and societies;
- ⊙ Severe stigma and discrimination attached to persons living with HIV/AIDS, combined with a perception that HIV only hits “undesirable” populations;

- ⊙ Massive, costly (and perhaps unreliable) public testing for HIV;
- ⊙ A near total lack of infrastructure and capacity to provide any HIV/AIDS-related services; whether through prevention programs; voluntary, anonymous counseling and testing; treatment; or care and support programs.

The window of opportunity to prevent a wide-scale epidemic is rapidly closing. Countries such as Ukraine and Russia are already beginning to exhibit changes in the dynamics of HIV infection. Previously, new HIV infections were found primarily among injection drug users. Now, a growing number of HIV cases are occurring through unsafe sexual behaviors.

Vulnerable young people are particularly susceptible to the epidemics of HIV/AIDS/sexually transmitted infections and injecting drug use. There are increasing cases of abandoned children, many of whom live on the street and are at high risk of sexual exploitation, drug addiction, and HIV infection. Additionally, with the economic situation of women deteriorating, the number of women engaging in sex work has increased considerably. The extremely high rates of sexually transmitted infections and the emergence of a bridging population of sex workers who inject drugs indicate the potential for a more widespread epidemic.

In Europe and Eurasia, several critical factors combine to fuel rising HIV rates. They include a dramatic surge in sexually transmitted infections (especially among those under 25 years of age), escalating drug production, trafficking, and abuse, deteriorating health care systems, the collapse of social safety nets, and socioeconomic turmoil brought on as nations shift to a market-driven economy. Additionally, widespread poverty, migration, and declining health and education services, along with severe ideological shifts, have led to a massive increase in individual high-risk behaviors such as unsafe sexual practices and illegal drug use.

With easy access to and strong demand for illegal drugs, consumption has increased dramatically, particularly in the Black Sea area, which remains a

regional gateway for drugs. Injecting drug users are at increased risk of HIV infection due to local patterns of drug preparation, drug markets, distribution channels, and injecting practices such as shared needles. In addition, a relatively large number of HIV-infected injecting drug users are prisoners; a significant rise in new infections is expected among this group because HIV prevention policies in prisons have been ineffective.

HIV vulnerability in Europe and Eurasia has been further increased by the lack of effective health and sex education. In addition, although imported and Russian-made condoms are sold at some kiosks in Belarus, Kazakhstan, Russia, and Ukraine, quality affordable condoms are not readily available. Official approaches to sex work and HIV prevention among sex workers have so far been either negligent or repressive. Sexually transmitted infection clinics, dispensaries, and gynecological centers do not provide these services.

## Regional Initiatives

In December 1999, USAID, UNAIDS and the government of Finland launched the Baltic Sea Initiative, a major effort on the part of the international donor community and the countries of the Baltic Sea region to confront the HIV/AIDS epidemic on a regional level. As part of the initiative, regional governments and the international community developed an action plan with the goals of regional coordination and cooperation, information exchange, and improved project development and implementation, in order to achieve an integrated, comprehensive, and effective response to the HIV/AIDS epidemic.

USAID has continued to support the Initiative by establishing the foundation for a Regional HIV/AIDS Network of Excellence. The network's goal is to organize and implement a coordinated 'systems' approach to the provision of financial and technical support to current programs and stakeholders, ultimately enabling them to:

- ⊙ Expand coverage of ongoing effective and sustainable HIV prevention programs among injecting drug users;



- ⊙ Strengthen ongoing sexually transmitted infection prevention and care programs with a specific focus on vulnerable groups; and
- ⊙ Develop and expand ongoing comprehensive and sustainable health promotion programs for young people, with emphasis on vulnerable groups.

Major network beneficiaries include Estonia, Latvia, Lithuania, and Kaliningrad and St.

Petersburg in Russia. USAID, in collaboration with UNAIDS, aims to use the Baltic Sea Initiative as a model for future HIV regional initiatives in the Central Asian republics and the Caucasus region. Additionally, as part of the Southeast Europe Regional Initiative, USAID plans to launch a condom social marketing program to focus on youth and the prevention of sexually transmitted infections.

## Romania

Romania is home to the highest number of pediatric HIV/AIDS cases in the European region. Since the first AIDS case was identified in 1985, approximately 9,022 pediatric and 2,014 adult cases of HIV/AIDS have been reported. Of the 9,022 children, 2,128 had died by March 2001.

The HIV/AIDS epidemic in Romania changed throughout the 1990s. The epidemic peaked in 1990 via blood transfusions to institutionalized children, but the practice was discontinued, and HIV incidence among children had decreased dramatically by 2000. The epidemic among children, however, masks an increasingly important HIV/AIDS trend among adults. During the last four years, the number of adult infections has tripled, most of which are reported to have occurred through sexual transmission (58 percent by heterosexual; 4.5 percent by homosexual and bisexual transmission). While the actual number of HIV-infected children may differ from the number reported by a factor of 2 or less, the actual number of HIV-infected adults living in Romania may be five to 10 times the number of reported infections.

Approximately 30 percent of known adult AIDS cases and 77 percent of known pediatric AIDS cases in Romania are attributed to unknown causes. Although little is known about sexual behaviors in Romania, commercial sex, trafficking of women, and homosexuality are increasingly visible parts of the culture. Sexually transmitted infections are also increasing rapidly, with about two-thirds of cases being registered in urban areas. Although the number of injecting drug users is increasing, this population accounts for only 0.2 percent of HIV cases.

To improve the life expectancy of persons living with HIV/AIDS, UNAIDS, together with the Ministry of Health and Family and the private sector, initiated a partnership to negotiate reduced drug prices for persons living with HIV/AIDS.

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<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>	7,000
<b>Total Population:</b>	22 million
<b>Adult HIV Prevalence:</b>	0.2%
<b>HIV-1 Seroprevalence in Urban Areas:</b>	
Population at High Risk:	0.5%
Population at Low Risk:	0%

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### *USAID-Supported Country Programs*

#### ***Social marketing***

In early 2000, USAID began funding Population Services International/AIDSMark in its social marketing campaign for safe sex and use of condoms for HIV prevention. The organization conducted an extensive information, education, and communication campaign, which included spots on television and radio using the slogan "Do what you want, but know what you are doing." Condoms are sold nationwide at a subsidized price.

#### ***Behavior change***

In recent years, USAID/Romania has funded a wide range of innovative programs to educate persons at high risk of contracting HIV. The Romanian Anti-AIDS Association, for example, implements several programs that target groups such as commercial sex workers, injecting drug users, and prisoners. The Romanian Society for Contraceptive and Sex Education trains family practitioners to enable them to

carry out basic health care delivery and HIV/AIDS counseling. A campaign to highlight the risks associated with unsafe sex was implemented in summer 2001 in Black Sea resort areas by Youth for Youth in collaboration with the Romanian Anti-AIDS Association, the Romanian Society for Contraceptive and Sex Education, and Population Services International/AIDSMark.

#### ***Children affected by HIV/AIDS***

In 2001, USAID awarded a small grant to the Texas Children's Hospital of the Baylor College of Medicine and the Constanta Department of Health. The partnership produced the Romanian-American Children's Center in Constanta, which provides sustainable, state-of-the-art care and treatment to HIV-infected children in individual or family homes around Constanta. The center includes an outpatient clinic, a small inpatient observation unit, classrooms, a library, and apartments for visiting health professionals.

Holt International, as part of a USAID project, assists parents of children affected by HIV/AIDS through development of parent associations aimed at strengthening ties to the community.

In addition, a grant funded by USAID and World Vision to the Romanian Anti-AIDS Association implements awareness programs for adolescents. In Romania, significant increases in syphilis infection have been documented in urban areas and among students. Since a rise in syphilis incidence is often correlated with an increase in HIV/AIDS, an activity to educate adolescents about condom use, HIV, and sexual activity was developed.

In conjunction with Kaiser Permanente and the Romanian Anti-AIDS Association, USAID supports theatre productions in

schools around Bucharest to educate young people on ways to prevent HIV transmission. As part of the South East Europe regional initiative USAID/Romania will continue to focus upon condom social marketing, HIV/AIDS/STD prevention, and targeted interventions for adolescents.

## Russia

Russia is witnessing explosive growth in the rate of HIV infection. According to UNAIDS, Russia now has the fastest growth rate of HIV infection in the world.

As of May 2001, Russia reported a cumulative total of 118,289 cases of HIV infection, but Russian health authorities estimate that the actual number of HIV-infected people may be 2 to 2.5 times higher. In the first nine months of 1999, more than 2,700 HIV cases were reported in Moscow alone—three times as many as in all prior years combined.

It is estimated that Russia has 3 million injecting drug users, which creates a considerable risk for a rapid spread of HIV among this highly susceptible group and among the general population. In 1999, most newly registered HIV cases occurred among injecting drug users. Kaliningrad, in northwestern Russia, was the first region to experience a large outbreak of HIV among injecting drug users, and has been hit particularly hard, with 2,681 cases of HIV reported as of November 2000. According to the Russian Ministry of Health, injecting drug users have accounted for more than 50 percent of all recorded HIV infections since 1987.

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**Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:** 130,000

**Total Population:** 145.5 million

**Adult HIV Prevalence:** 0.18%

**HIV-1 Seroprevalence in Urban Areas:**

Population at High Risk: 0.7%

Population at Low Risk: N/A

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In March 1998, the United States and Russia began collaborating to control the spread of HIV and other sexually transmitted infections after a visit by high-ranking AIDS experts from Russia to the United States. USAID, the Centers for Disease Control and Prevention, and Population Services International/AIDSMark worked with the Russian Ministry of Health to develop a multiyear strategy (1998–2000) aimed at HIV prevention among high-risk groups.

In March 2000, an assessment team reviewed the original strategy, assessed progress, and proposed a follow-on strategy for 2001–2003. Both the original and future strategies incorporate the strengths of governmental and nongovernmental sectors to improve service delivery and public information capacity to reach vulnerable populations. Recommendations from the Ministry of Health and an analysis of HIV/AIDS rates led to the selection of Moscow City and Saratov Oblast as project demonstration sites.

### *USAID-Supported Country Programs*

#### ***Behavior change communication***

The present USAID program stresses prevention of HIV among injecting drug users (IDUs) and prostitutes in Moscow city and Saratov Oblast. Throughout the

use of media and print materials, concerts and youth-oriented activities, the general population and youth are being educated about prevention techniques.

#### ***Capacity building***

USAID has supported the development of two partnerships between Russian and American HIV/AIDS nongovernmental organizations. The partnerships have developed prevention strategies for high-risk groups and have strengthened the capacity of the Russian partners to design and implement HIV prevention programs. In the future, this model will be expanded to develop Russian-to-Russian nongovernmental organization partnerships.

#### ***Sexually transmitted infection control***

USAID is working with the Centers for Disease Control and Prevention and Russian sexually transmitted infection and HIV/AIDS specialists to sponsor training workshops and national conferences focusing on interventions for high-risk groups. Services for vulnerable groups will be improved through surveys, upgrades to laboratory equipment, training, and introduction of new methods for sexually transmitted infection diagnosis and treatment guidelines.

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## Ukraine

The number of HIV/AIDS cases is escalating rapidly in Ukraine, where AIDS deaths doubled from 1999 to 2000. As of May 1, 2001, almost 39,000 Ukrainians were registered as HIV-positive, although health officials estimate the actual number to be closer to 500,000, or about 1 percent of the population. The leading cause of HIV transmission remains injecting drug use (62.5 percent of total cases), although the proportion of



AIDS cases attributed to this mode of transmission has declined over the last five years. This trend indicates that HIV is spreading from high-risk groups into the general population.

Increasing numbers of injecting drug users are between 14 and 28 years old, and up to 80 percent of HIV-infected persons are in the 15- to 29-year-old range. Since 1996, the number of HIV-infected prisoners, many of whom are drug users, has increased dramatically in Ukraine.

The Ministry of Health's new HIV/AIDS policy emphasizes provision of voluntary testing, pretest and posttest counseling, information dissemination on prevention methods, distribution of condoms, and disinfecting agents for needles and syringes. Given the high cost of medications, treatment for people living with HIV/AIDS is limited.

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<b>Estimated Number of Adults and Children Living with HIV/AIDS, end of 1999:</b>		500,000
<b>Total Population:</b>	49.1 million	
<b>Adult HIV Prevalence:</b>	1%	
<b>HIV-1 Seroprevalence in Urban Areas:</b>		
Population at High Risk:	0.6%–3.1%	
Population at Low Risk:	N/A	

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#### *USAID-Supported Country Programs*

**Behavior change communication**  
From 1997 to 1999, USAID, through Johns Hopkins University, provided technical support to five nongovernmental organizations undertaking behavior change interventions with high-risk target populations. Behavior change communication materials were developed to support these interventions.

#### *Collaborative efforts*

USAID and the European Union currently implement a joint HIV/AIDS Prevention and Awareness Program in Ukraine. The European Union has committed \$1.8 million and USAID/Kyiv has committed \$2.8 million. As part of this effort, the USAID-funded International HIV/AIDS Alliance is developing a national clearing-house to disseminate best practices, provide information on consultant resources, and provide current HIV/AIDS data. The organization also supports 12 Ukrainian nongovernmental organizations working in this area. The British Council, which is funded by the European Union, is implementing youth-oriented prevention programs in five selected oblasts.

#### *Capacity building*

In September 2000, USAID/Kyiv provided funds to the Counterpart Alliance for Partnership to strengthen the capacity of Ukrainian health nongovernmental organizations to effectively deliver health services, including HIV/AIDS and sexually transmitted infection prevention services aimed at injecting drug users, and sex workers and their clients.

#### *Prevention of mother-to-child transmission*

The USAID-supported American International Health Alliance works with the United Nations Children's Fund, Medecins Sans Frontieres, and Odessa health care institutions to implement a program to prevent mother-to-child transmission of HIV.

to prevent an HIV epidemic from spreading into the general population. Presently, the total number of documented HIV cases in the region remains relatively low, with Kazakhstan reporting 1,799 cases; Kyrgyzstan, 92; Tajikistan, 22; Turkmenistan, 4; and Uzbekistan, 302. An overwhelming number of HIV infections in all five countries are related to injecting drug use. In Kazakhstan, for example, health officials reported that 85% of new HIV cases are caused by injecting drug use. In Uzbekistan, this mode of transmission accounts for 71% of new HIV cases. Without immediate intervention, the potential for a slower, more generalized heterosexual epidemic is imminent. Sexually transmitted infections, such as syphilis and gonorrhea, have increased 100-fold since 1991, and a growing number of female injecting drug users are engaging in commercial sex work, which may provide a bridge between the high-risk and general populations. Young people are particularly vulnerable to HIV infection; the majority of drug users and sex workers in the region are under age 30.

Unemployment, poverty and increased drug use in Central Asia contribute to the spread of HIV/AIDS. All five Central Asian countries serve as drug trafficking routes from Afghanistan to Russia and Western Europe. This has grave consequences for Central Asia and in particular, Tajikistan, which shares a 1,350 km border with Afghanistan. Local drug consumption patterns are influenced by ready access to drugs. People are switching from alcohol to heroin, which is cheaper, and heroin users are starting to switch from smoking or snorting to injection, because it is a more efficient method of drug ingestion.

According to a recent USAID-funded HIV/AIDS assessment, the retail price of a single dose of

## Central Asia

Five Central Asian countries—Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan—are faced with a unique opportunity: to intervene early and decisively

heroin in Kyrgyzstan is as low as \$.50-\$1. Low prices have led to an estimated 135,000 injecting drug users in Tajikistan, and perhaps 200,000 in Kazakhstan.

Unfortunately, the implementation of effective HIV/AIDS awareness and prevention programs is hampered by a severe lack of governmental resources. International organizations ultimately provide a large share of funding for existing programs, but have not been coordinated enough to ensure the best use of scarce resources. All five countries have recognized the impending danger of an HIV epidemic, and have approved national programs on HIV/AIDS. National governments have taken positive steps to modify existing legislation to include HIV/AIDS detection and confidentiality provisions.

Despite growing emphasis on a coordinated regional response, it is clear that any HIV/AIDS initiative in Central Asia must accommodate a cultural reluctance to confront AIDS. Historically, National AIDS Centers in the former Soviet Union focused on mandatory mass screening, based on traditional “identify and control the carrier” approaches. Those living with HIV/AIDS were afraid to seek treatment, fearing government retribution; similar concerns are pervasive today.

#### **USAID-Supported Regional Activities**

USAID recognizes the importance of intervening early within Central

Asia to prevent the spread of a generalized HIV epidemic. Efforts to date have focused on the following:

#### ***Disease surveillance, reporting, and blood bank screening***

USAID has supported national government efforts to strengthen HIV surveillance and reporting since October 2000. Specifically, activities implemented by the Centers for Disease Control and Prevention have improved existing health systems and trained experts to detect, monitor, and respond to the HIV/AIDS epidemic, based on epidemiological patterns facing different populations. Blood bank screening techniques and laboratory methodologies have also been improved to prevent the transfusion of HIV-positive blood and to ensure quality control in labs.

#### ***STI diagnosis and management***

USAID has funded Abt Associates to use a syndromic management approach to improve diagnosis and treatment of sexually transmitted infections in Kazakhstan. The model site has served as a training ground for enhancing the skills of primary health care providers to educate patients and evaluate patient risk for HIV/AIDS and other sexually transmitted infections. The project's initial success has led to plans to expand the approach in Kyrgyzstan.

#### ***Infection control***

USAID has funded several partnership activities through the American International Health Alliance, and has succeeded in

drafting and adopting new hospital-based infection control procedures to reduce the transmission of HIV/AIDS among health care workers and patients.

#### ***Behavior change communications***

Several strategies have been used to raise general awareness and target HIV/AIDS/sexually transmitted infection prevention messages. First, USAID/Central Asia has established a toll-free hotline to address peoples' confidential health questions. The activity also promotes HIV/AIDS education through materials and media campaigns that encourage condom use. Secondly, a network of USAID-supported Women's Wellness Centers have been instrumental in providing consumers with information, education, and access to quality services providing HIV/AIDS/sexually transmitted infection prevention.

#### ***Harm reduction/injecting drug use***

USAID has funded a limited number of harm reduction study tours permitting local HIV/AIDS professionals to travel within the Central Asian republics, as well as to Lithuania, to work with regional counterparts and learn about model HIV/AIDS interventions being implemented to target injecting drug users and commercial sex workers.

# HIV/AIDS Funding

## Fiscal Years 1997-2000 (all numbers in thousands)

EUROPE & EURASIA BUREAU	FY 1997	FY 1998	FY 1999	FY 2000
Kazakhstan	–	–	81	231
Kyrgyzstan	–	–	35	90
Russia	900	1,100	1,710	1,650
Ukraine	426	–	150	500
Uzbekistan	–	–	55	32
Central Asian Regional	–	–	18	24
Central Eastern Europe Regional, incl. Romania	–	199	135	502
Newly Independent States Regional	56	–	175	425
<b>Europe and Eurasia Bureau Total</b>	<b>1,382</b>	<b>1,299</b>	<b>2,359</b>	<b>3,454</b>

AFRICA BUREAU	FY 1997	FY 1998	FY 1999	FY 2000
Angola	–	–	–	1,500
Benin	1,000	1,450	1,200	1,025
Democratic Republic of the Congo	–	464	1,914	1,500
Eritrea	200	500	217	500
Ethiopia	3,000	4,884	5,540	7,600
Ghana	1,900	3,078	4,000	4,000
Guinea	1,200	1,300	1,200	1,725
Kenya	3,000	3,200	4,450	9,200
Madagascar	500	500	500	800
Malawi	5,000	2,408	2,685	6,000
Mali	2,200	1,630	2,220	2,500
Mozambique	3,400	3,730	2,820	5,600
Namibia	–	–	–	1,000
Nigeria	800	1,580	2,815	6,675
Rwanda	2,000	500	3,000	4,150
Senegal	500	2,303	2,775	4,200
South Africa	2,000	3,383	2,950	6,450
Tanzania	5,000	3,513	4,000	6,273
Uganda	5,150	4,920	7,010	9,300
Zambia	3,600	3,070	4,250	9,100
Zimbabwe	4,200	1,950	1,850	5,000
Africa Regional	2,850	2,500	3,749	5,300
REDSO/WCA*	3,300	3,656	3,605	8,201
REDSO/ESA**	200	390	302	1,200
Sahel Regional	101	100	–	100
<b>Africa Bureau Total</b>	<b>51,101</b>	<b>51,009</b>	<b>63,052</b>	<b>108,899</b>

\* REDSO/WCA: Regional Economic Development Services Office for West and Central Africa

\*\* REDSO/ESA: Regional Economic Development Services Office for East and Southern Africa



# HIV/AIDS Funding

## Fiscal Years 1997-2000

(all numbers in thousands)

ASIA & NEAR EAST BUREAU	FY 1997	FY 1998	FY 1999	FY 2000
Bangladesh	772	1,351	2,000	3,007
Burma	–	–	154	–
Cambodia	–	1,000	3,000	2,050
Egypt	260	100	340	–
India	1,349	4,300	6,450	8,500
Indonesia	3,051	6,430	–	4,460
Nepal	675	3,120	1,700	2,000
Philippines	2,450	1,550	2,500	1,500
Asia & Near East Regional	5,513	5,783	4,996	–
<b>Asia &amp; Near East Bureau Total</b>	<b>14,070</b>	<b>23,634</b>	<b>21,140</b>	<b>21,517</b>

LATIN AMERICA & CARIBBEAN BUREAU	FY 1997	FY 1998	FY 1999	FY 2000
Bolivia	800	868	800	800
Brazil	2,000	2,000	2,000	2,000
Dominican Republic	2,050	1,853	2,300	2,313
El Salvador	250	295	300	250
Guyana	–	–	–	200
Haiti	1,728	1,384	1,350	1,489
Honduras	1,508	1,500	1,400	1,400
Jamaica	1,530	2,243	1,700	1,825
Mexico	1,245	400	1,050	1,200
Nicaragua	–	200	390	500
Peru	250	250	300	500
G-CAP*	4,700	3,650	2,700	3,150
Latin America Regional	–	500	60	–
<b>Latin America &amp; Caribbean Bureau Total</b>	<b>16,061</b>	<b>15,143</b>	<b>14,350</b>	<b>15,827</b>

\* G-CAP: Guatemala-Central America Program

USAID/WASHINGTON	FY 1997	FY 1998	FY 1999	FY 2000
Food for Peace Office	–	–	–	10,000
Global Bureau	34,738	32,333	37,000	38,750
Policy & Program Coordination Bureau	239	150	–	450
Private/Voluntary Cooperation Office	1,312	1,200	1,200	1,150
<b>USAID/Washington Total</b>	<b>36,289</b>	<b>33,683</b>	<b>38,200</b>	<b>50,350</b>
<b>Grand Total</b>	<b>118,903</b>	<b>124,768</b>	<b>139,101</b>	<b>200,047</b>

**The following projects and partners are supported by USAID's HIV/AIDS Division:**

**AIDSMark (Population Services International)**

Under an agreement with USAID, Population Services International's AIDS Social Marketing (AIDSMark) program works to implement HIV/AIDS prevention and mitigation social marketing interventions worldwide for USAID, both on a regional and country-specific basis.

<http://www.psiwash.org>

**Centers for Disease Control and Prevention**

The Centers for Disease Control and Prevention works to strengthen the delivery of health programs in developing countries by using their technical expertise to address the surveillance of and response to infectious diseases such as HIV/AIDS, tuberculosis, and other health problems in the developing world.

<http://www.cdc.gov>

**FANta (Academy for Educational Development)**

FANta is designed to leverage maximum nutritional impact of nutrition and food security-related programs implemented by USAID and its partners in developing countries.

<http://www.fantaproject.org>

**FOCUS on Young Adults (Pathfinder International)**

Pathfinder International's FOCUS project works to improve the health and well-being of young adults by identifying effective adolescent initiatives in developing countries.

<http://www.pathfind.org>

**Global Health Council**

Through its Global AIDS Program, the Global Health Council acts as liaison, educator, and coalition builder for the U.S. and indigenous private sector entities working in HIV/AIDS prevention, as well as serving as a source of information on the global AIDS pandemic.

<http://www.globalhealthcouncil.org>

**HORIZONS (Population Council)**

Under a cooperative agreement with USAID, the Population Council's HORIZONS (HIV Operations Research) project features practical, field-based, program-oriented operations research to identify best practices for the prevention of HIV/AIDS and other sexually transmitted infections.

<http://www.popcouncil.org/horizons>

**IMPACT (Family Health International)**

Family Health International's IMPACT (Implementing AIDS Prevention and Care) project designs, develops, manages, and monitors country-specific HIV/AIDS prevention, care and treatment interventions.

<http://www.fhi.org>

**International HIV/AIDS Alliance**

The International HIV/AIDS Alliance improves the capacity of community organizations to address the HIV/AIDS epidemic and promotes partnerships among local nongovernmental organizations and government services.

<http://www.aidsalliance.org>

**LINKAGES (Academy for Educational Development)**

LINKAGES is the principal USAID initiative for mainstreaming improved breastfeeding and related maternal and child dietary practices into HIV/AIDS programs.

<http://www.linkagesproject.org>

**Measure DHS+ (Macro International)**

Macro International's Measure DHS+ project continues USAID's involvement in global data collection with an increased focus on country data needs and on utilization of data for evaluation and monitoring purposes. Their Demographic and Health Survey includes an expanded set of questions on HIV/AIDS and sexually transmitted infections.

<http://www.macrint.com/dhs>

**PHRplus (Abt Associates)**

The Partners for Health Reform (PHRplus) project is the USAID's flagship project in health policy and systems strengthening. PHRplus assists in the development of disease surveillance systems that are needed to address specific program needs as well as broader health information systems that support the management and delivery of more effective health services.

<http://www.phrproject.com/>

**The Policy Project (The Futures Group International)**

The Policy Project provides assistance to public and private sector institutions to strengthen their capabilities to contribute to the development of programs, the allocation of resources, and the implementation of effective HIV/AIDS policies and programs.

<http://www.policyproject.com>

### **Population Communication Services (Johns Hopkins University)**

Population Communication Services is administered by the Center for Communication Programs at the Johns Hopkins University School of Public Health. Population Communication Services offers technical assistance, training, and financial support to partners in more than 65 countries, helping them develop effective information, education, and communication programs promoting HIV/AIDS prevention.

<http://www.jhuccp.org/pcs.stm>

### **Program for Appropriate Technology in Health**

The Program for Appropriate Technology in Health, or PATH, offers technologies and programmatic strategies to help prevent and control the spread of HIV/AIDS and other sexually transmitted infections. PATH has worked on the development of health technologies suitable for low-resource settings and has provided assistance to governments and local agencies to develop essential technologies, including media campaigns to raise public awareness, education and counseling programs for youth and high-risk groups, training to improve the quality of care, and strategies for disease management.

<http://www.path.org>

### **Rational Pharmaceutical Management Plus (Management Sciences for Health)**

Rational Pharmaceutical Management Plus works to improve the availability of health commodities of assured quality for PHN interventions. In the area of HIV/AIDS, Rational Pharmaceutical Management Plus addresses the commodities management issues of the disease as well as infection diseases programs and the implementation problems involved in scaling up.

<http://www.wsh.org>

### **The Synergy Project (TvT Associates)**

TvT Associates' Synergy Project provides technical assistance to design and refine HIV/AIDS strategic objectives and results frameworks; as well as monitoring processes, outcomes, and impact of HIV/AIDS prevention and mitigation services, and collecting and disseminating research and evaluation findings.

<http://www.synergyaids.com>

### **UNAIDS**

UNAIDS, the Joint United Nations Programme on HIV/AIDS, strengthens the capacities of national governments for an expanded response to HIV/AIDS, provides technical and policy leadership in the global fight against HIV/AIDS, and facilitates international donor cooperation.

<http://www.unaids.org>

### **U.S. Bureau of the Census**

The U.S. Bureau of the Census maintains the HIV/AIDS International Surveillance Data Base, provides demographic and economic models of the impact of HIV/AIDS in the developing world, and disseminates information through publications and presentations throughout the world.

<http://www.census.gov>

### **U.S. Peace Corps**

Under a cooperating agreement with USAID, the U.S. Peace Corps promotes and expands its community-based efforts in HIV/AIDS prevention and care, programs for women and girls, and programs for youth, both in and out of school.

<http://www.peacecorps.gov>

### **University of California San Francisco**

The University of California at San Francisco has a cooperative agreement with USAID to create an Internet databank of detailed epidemiological profiles for priority countries, for in-country strategic planning purposes.

<http://ari.ucsf.edu/ab.html>

### **Voice of America**

Voice of America is funded by USAID to carry out intensive on-the-ground reporting on diverse aspects of the HIV/AIDS pandemic.

<http://www.voa.gov>

### **World Health Organization**

USAID provides support to the World Health Organization for the development, implementation, and evaluation of health programs and studies of infectious diseases, maternal and child health, and HIV/AIDS.

<http://www.who.ch>



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